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CHRONIC CALLOUS ULCER OF THE LEG AND ITS TREATMENT.

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Although a matter appertaining to minor surgery, the question of chronic callous ulcer of the leg is one of very great interest and importance. As a minor ailment, few affections cause a greater amount of continued misery and disappointed hopes. In regard to this and other forms of ulceration, a very full and exhaustive paper was read at the Brighton meeting of the British Medical Association, by Dr. A. W. Williams, in July, 1913, and subsequently published in the *British Medical Journal* in October of the same year. This paper is deserving of more than a passing notice, as it is perhaps the most extensive and able contribution on the subject that has ever appeared. Those interested in the subject will find it a perfect mine of information. Not only so but a very useful and extensive bibliography is added. On the question of rest, which has always occupied a foremost place in the treatment of chronic ulcer, the author states: "These cases, above all others, appeal to our sympathy, on account of the brave heroism of the majority of the sufferers. The brief reply, pregnant with noble self-sacrifice so constantly given to our advice for the patient to lie up or to go to the infirmary is: 'Doctor, I cannot, for if I did my home would be broken up, and what would become of my children.' " My chief reason for quoting this short extract from the writings of an obvious authority on the subject is to call prominent attention to this question of rest. It has always been thought, both now and formerly, that rest for a certain period in the healing of this particular ulcer was essential. The method I am about to recommend has nothing to do with rest, and a patient may pursue his or her avocations with perfect freedom during the whole period of treatment. That rest would be an important factor in the rapid healing of an ulcer is undoubted, on account of its influence on the circulation. What is not so easily understood, however, is the character of the minute changes in the small venous radicles, and at a certain age perhaps on the arterial side as well. A limb may be frankly varicose, yet if the small surface vessels have escaped, the varicose condition generally will be negligible, either in producing an ulcer, or affecting it for the worse when actually present. The subject, from this particular point of view, requires further elucidation. That it is of considerable practical importance is evident from the following case. A lady at present under my care had a fairly large ulcer satisfactorily healed up on no less than three occasions at one time and another, yet each time, after a variable interval, the healed surface again ulcerated. Although the whole limb was moderately varicose, the small surface vessels scarcely seemed

to be implicated. On dealing with the veins, however, the ulcer remained satisfactorily healed. It may be laid down as a general rule then, that where an ulcer is accompanied by a varicose condition of the limb, the latter will have no effect on the ulcer, except the small vessels of the skin are implicated as well. If this was clearly kept in mind, it would obviate the too common practice of calling every ulcer accompanied by varicose veins a "varicose ulcer." The chronic callous ulcer, whether due to venous troubles or not, is generally situated between the knee and the ankle, and usually, but not invariably, in front. As is well known, it is a disease of middle life, and commonest in women. That poor surroundings and bad hygienic conditions have a considerable influence in its production is evident from the class of people it generally attacks. There are many points of interest in connexion with the ulcer itself that might be alluded to, but these scarcely come within the scope of a short paper dealing with treatment. One point, however, that has received much attention, and has to do with the beginning of treatment, is the character of the borders of such ulcers. These are usually extremely hard and indurated, and considerably raised above the surface. The induration is due to the heaping up of epithelium, and the conversion of the exudates from the vessels into hard, fibrinous, organized layers. The vessels most largely responsible for this are the lymphatics. With a blunt scalpel, the borders may be peeled off in successive layers, till a raw and bleeding surface is reached. This may be done as a preliminary to the method I adopt, although I do not regard it as essential. The example of the great Edinburgh surgeon, Syme, is occasionally followed, and blistering resorted to. This is generally efficacious, but may be attended with unpleasant and even harmful results. The number of applications that have been tried at one time or another is almost unlimited, and no good purpose would be served by even enumerating them. No system of treatment is of any avail that does not include even and continuous pressure. The system of Baynton, and later that of Unna, had those ends in view. Whilst a certain amount of success can be claimed for both methods, the difficulties of application greatly outweigh their advantages. The method that I recommend is by the use of Martin's rubber bandage. It is probable that Martin himself first introduced this particular plan. At any rate, I make no claim to originality, as I read about the treatment by this means in some medical publication many years since, and have used it with great advantage ever since. The complete details are not to be found in the surgical literature of the present day. An incomplete account of the plan may be found in "A System of Surgery," by Treves (1895). This permits a dressing to be put under the bandage, a procedure that must on no account be adopted. Finally, one great advantage of the plan I recommend is that any per-

son of ordinary intelligence can carry it out after a single demonstration. There are two conditions that may require consideration, in addition to the bandage. The ulcer may be of such a size that grafting may be necessary, and the veins, as I said before, may require surgical treatment. With these two reservations, I hold that the use of the bandage will cure any chronic ulcer of the leg, provided, of course, that the plan is strictly carried out in its integrity.

Perhaps I can best accomplish what I want to state by giving the daily routine that must be followed. A good Martin's rubber bandage, about ten or twelve feet long, is selected. The exact length will depend, of course, to some extent on the dimensions of the leg. The bandage is applied to the affected leg before the patient gets out of bed; this is indispensable, as is every subsequent step. The bandage starts at the base of the toes, and is carried by various turns around the foot to the ankle. A turn is now taken around the lowest part of the leg, and then again around the foot. This will only leave the heel exposed, and a small triangular part at the inner and outer part of the ankle. The bandage is then continued up the leg, each turn fairly overlapping the one below. The turns must not on any account be reversed. When the knee is reached, two turns of a figure-of-eight must be taken, and the bandaging completed by two direct turns just above the patella. The bandage is now securely fastened. In the course of the bandaging up the leg, the ulcer itself is covered by the bare bandage. On no account must any dressing be interposed between the bandage and the ulcer itself. If at all possible, it is advisable to cover the ulcer with one turn of the bandage. If the ulcer is not too large, this is quite feasible, but in any case it is not of much importance. The bandage is worn during the day, and no restriction is made as to the kind of work undertaken, whether it is hard, manual labour or the opposite. At bed-time the elastic bandage is taken off, but this is not done till the patient is in bed, and the ulcerated leg in a horizontal position. The soiled part of the bandage is sponged and dried, and the bandage itself hung loosely on some article of furniture during the night. The affected leg is now washed with hot water and soap, care being taken to cleanse the edges of the ulcer as well as possible. When this is finished, the neighbourhood of the ulcer and the ulcer itself is washed with a carbolic lotion of the strength of 1 in 60. Afterwards, the ulcer and the parts around it for an inch or two are covered with three pieces of lint, soaked in the above solution. A piece of oiled silk is put over this and the leg comfortably bandaged from the toes to the knee with a calico bandage. This completes the daily routine of the treatment of the ulcer. From the above short description, it will be noted how easily and with what little trouble the treatment is carried out. In hanging up the bandage at night in loose folds, it has time to get thoroughly dry before morning. This is a matter of some importance, as rolling it up at night as soon as it has been cleaned will not only deteriorate it, but make it less adaptable. The carbolic lotion, it may

be noted, should always be made up with a certain amount of glycerine, as it dissolves much better. One drachm of the acid, two ounces of glycerine, and eight ounces of water make a suitable lotion. If a tablespoonful of this is put into half a pint of hot water, it will be quite strong enough for the above purpose.

It might be as well to repeat that when the dressing is taken off in the morning and the rubber bandage is put on, the patient must under no circumstance get out of bed till this is done. The advantages of putting on the bandages morning and evening with the limb in the horizontal position are due to their effect on the venous circulation in that particular posture. The little procedure then must be carried out in bed, but at such times that obviates any inconvenience and scarcely at all interferes with the daily routine of life. Where the ulcer is large and the discharge copious and foul, the irritation and discomfort to the leg may be considerable before the day is over. If such is the case, there is nothing for it but to remove the bandage, cleanse the soiled part, wash the leg with the lotion, and re-apply. But such a condition is not very common. Having used the above method for many years, I can warmly recommend it. It is the only way in which I have been able to deal with such obstinate and refractory ulcers, and the *raison d'être* of this short article is to try and make the method more widely known.

NOTES ON SEVERAL CASES OF PELLAGRA.

By H. J. Brennand, B.A., M.D., M.S. (Sydney),

Staff Surgeon, H.M.A.S. Melbourne.

Having been shown several cases of pellagra by the courtesy of Dr. Castle and Dr. W. M. McDonald, the Medical Superintendents of the General Hospitals at Kingston, Jamaica, and Antigua, the following notes and a photograph given me by Dr. McDonald may be of interest to the readers of the *Journal*.

Cases of pellagra are very common in most of the West Indian Islands, and in most of the countries of Southern Europe and North Africa, and in Mexico, United States, Brazil and Argentina. So far as I am aware, it has not been met with in Australia or New Zealand, but cases have been reported from New Caledonia by Neirte. In the West Indian Islands the bulk of the population is coloured, and the majority of them is composed of very poor agricultural labourers and their families. The 36 patients whom I have seen belonged entirely to this peasant class. The symptoms, as is well known, fall into three groups:—

- (1) A remitting but intractable erythema of the exposed parts of the body—the arms, hands, feet, legs and face and neck, as in the photograph.
- (2) A progressive emaciation. All the cases seen in the West Indies resemble living

skeletons, and are extremely weak and emaciated.

- (3) Profound mental degeneration. Attacks of melancholia, alternating with acute mania, occur, leading finally to dementia and death.

Locality.—In Antigua, the chief occupation of the people is agriculture, sugar-cane, maize, and cotton being the chief crops. The island is a dry one, with no streams, the people depending entirely on the rain for their water supplies. The surface of the country is hilly, and in the valleys rain-water swamps are filled up after the heavy, seasonal rains. In Jamaica, the whole island is more mountainous, and the rainfall is heavier. The sugar-cane is grown on both islands in the valleys. The disease is found to prevail in these districts chiefly, and to be more or less endemic there.

Ætiology.—Dr. McDonald, of Antigua, who has done a great amount of work in connexion with pellagra in that island, is inclined to agree with

with life in such surroundings, may be contributing causes. Observers in pellagrous countries cannot agree that diseased maize is the cause, as in some maize is not eaten at all. And the literature of the subject is full of contradictions. Some medical men in the West Indies incline to the idea that the disease is due to constant exposure to the sun's rays, but this again is not the case in some European countries which have a mild climate. The early cases in Jamaica and Antigua certainly resemble sunburn erythema, and the patches certainly pain and smart on exposure to the sunshine.

Sambon, I believe, considers that the disease may be due to some protozoal organism introduced into the human blood by the bite of the simulum fly, but careful search by this observer and others failed to reveal the presence of simulia in Antigua at any rate. So that as far as this island is concerned no definite theory can be relied on.

Mental Symptoms.—Several advanced cases of melancholia, with a marked tendency to suicide, have occurred among the West Indian cases, and the lunatic asylum at St. John's, Antigua, includes several of these. The girl, whose photograph is sent with these notes, is a melancholic. Other cases become epileptic, paralytic and demented.

The disease is increasing in the West Indies, and the Rockefeller Institute, of New York, has taken the matter up, and in a few months' time some competent observers are to be sent to Antigua and elsewhere to study the whole question thoroughly, under the ægis of this beneficent trust.

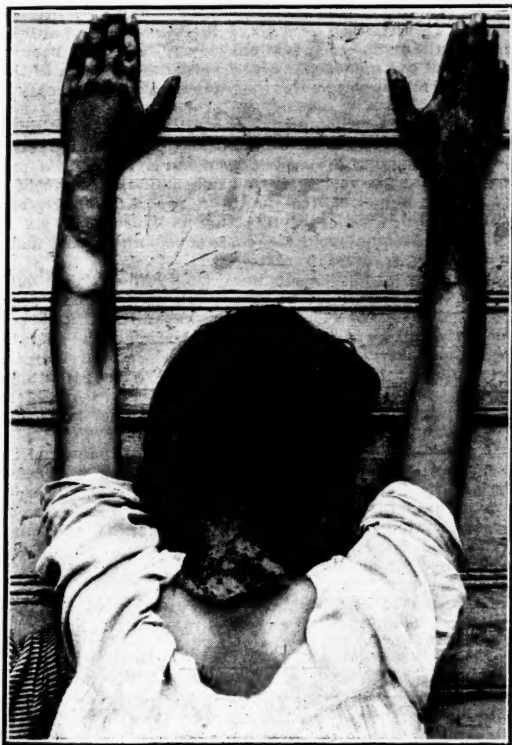
Reports of Cases.

TORSION OF THE SMALL INTESTINE; RESECTION OF EIGHT FEET OF INTESTINE; RECURRENCE OF TORSION.

By W. L. Kirkwood, M.B., Ch.B.,
Wollongong, New South Wales.

The points of interest in this case justify my reporting it in considerable detail.

Mrs. E.G., æt. 60, for long a sufferer from dyspepsia and constipation, was seized with abdominal pain when at dinner, about 1 p.m. on 2nd August, 1913. She did not then vomit, but the pain continued with varying intensity till 6 p.m., when she was seen on my behalf by Dr. John Kerr, who found her suffering from a considerable degree of cramping pain, associated with a little tenderness in the appendicular region, but no rigidity. She had vomited twice during the afternoon. The pulse-rate was 70, and the temperature 98.4°. He gave her morphine, gr. ¼, by hypodermic injection, and told her to send for me by eight o'clock if there was no improvement. I was called at 2 a.m. The patient was suffering great abdominal pain, gripping in character, and referred chiefly to the upper abdomen and left side. There was no localized tenderness, and very little general tenderness. She had vomited twice since 6 p.m. The bowels had not been opened. The pulse was 76 and the temperature 99.6°. A soap and water injection produced a large evacuation of the bowel. I gave morphine, gr. ¼, by hypodermic injection, and advised the application of hot stupes to the abdomen. I returned at 7 a.m. The pulse was then 92 per minute and the temperature 98°. The pain was continuing as before; vomiting had occurred once in the interval; the abdomen had become distended, and there was dullness in the flanks. I failed to make a diagnosis, but thought chiefly of perforated gastric ulcer



the maize theory of the disease. The labourers are very poor, maize-meal is their chief article of diet. They rarely get meat or fat to eat. They are not able to get fish in the interior of the island, being too poor to purchase it, and they prefer to sell their chickens and eggs to eating them. They live crowded together in tiny cabins, and I have seen as many as ten individuals living in a hut about 12 feet by 10 feet, and consisting of one room only. The negro villages consist of huts like this, so that an almost exclusive diet of maize-meal, combined

and torsion of an ovarian cyst. There was, however, no abnormality discoverable in the pelvis. Immediate operation was urged, and consent was ultimately obtained. With much delay, the patient was moved to hospital, and operation commenced about noon, 23 hours after the occurrence of her first symptom. By this time the abdomen was enormously distended with fluid, the pulse had become quite imperceptible at the wrist, and the temperature was 97°. Dr. W. B. Kerr gave the anæsthetic and commenced the administration of saline under the breasts at once. Dr. John Kerr assisted me at the operation, and to both I am much indebted for help and suggestions.

A right rectus incision was made opposite the umbilicus. A large quantity of fluid, at first slightly turbid and later blood-stained, escaped. Several coils of small intestine thrust themselves into the wound. On examination, it was seen that many feet of bowel were involved. The bowel was distended, cedematous, without gloss, and of a deep chocolate colour. The mesentery was similarly discoloured, swollen and pulseless. Further investigation revealed that the mesentery had undergone torsion, and that the condition was due to a strangulation of the mesenteric vessels. The torsion, which was from right to left, or "clockwise," was unwound; but the pulsation did not return to the mesenteric vessels, and the condition of the bowel did not improve. The limits of the diseased area were sharply defined, a slight constriction of the lumen, such as Moynihan figures as occurring in mesenteric embolism, marking the termination of the area. Resection appeared to be the only course open. The bowel was divided between clamps, six inches above and six inches below the diseased area, and the mesentery excised along a line close to the pulseless, discoloured portion. An end-to-end anastomosis of the intestine was made, silk being used as suture material. The edges of the gap in the mesentery were brought together with catgut. The abdominal wound was closed with silk, and the patient returned to bed, no worse than at the commencement of the operation.

In all, five pints of saline solution had been given under the breast. The removed portion of bowel was found to measure eight feet. It soon became evident that the patient had been relieved. In about an hour it was possible to feel a flicker at the wrist, and the patient gradually made an uneventful recovery, the bowels being opened by enema the day after operation. On the tenth day an abscess was discovered in the abdominal wound. There had been no pyrexia. About two ounces of stinking pus were evacuated. She left hospital 4½ weeks after the operation, apparently well, but still weak and with a tendency to looseness of the bowels. This looseness proved very troublesome, and caused great loss of weight, but was ultimately controlled by the use of bismuth and opium. About a month after going home she began to complain of griping, noisy abdominal pains, occurring frequently every day. She herself described the sensation as being an effort of the bowels to overcome an obstruction. Events showed that her interpretation was correct. Meantime, however, the diarrhoea subsided, the noisy abdominal pains became less, and she came to regard herself as well.

On 24th May, 1914, nine months after the original operation, she sent for me again, on account of symptoms similar to her former illness. About two hours before I saw her, she was seized with griping pain, referred chiefly to the epigastrium and "working" towards the left side of the abdomen. She vomited when the pain came on, and once afterwards. The bowels had been opened by a soap and water injection. There had been no constipation. There was again no localized tenderness, but there was obviously great abdominal discomfort and mental alarm. The pulse was 90 and the temperature 98.6°. I felt certain that the illness was similar to the former one. I had her removed to hospital, and was able to operate within four hours of the onset of her symptoms. The abdomen was again full of fluid; coils of distended, discoloured bowel again presented themselves; there was again a "clockwise" torsion of the small intestine. There were bands of adhesion present between the old line of intestinal suture, the line of mesenteric suture and the omentum, but these did not seem to have any relation to the torsion, and were only divided after the torsion was unwound. The intestine at the line of suture was very stenosed. Above the stenosis

the bowel was both dilated and hypertrophied. The circulation of the unwound coils and of the mesentery was found to be good, and the bowel viable. I considered the question of dealing with the stenosis, but decided to leave it alone, as not being essential to present relief. The patient was returned to bed in good condition, and an uninterrupted recovery followed.

The bowels have since been regular, without diarrhoea or constipation, and there has been no recurrence of exaggerated peristalsis, producing the noisy, griping pain previously experienced. The patient some time after the second operation said that I must have put something right which was wrong before, as, after her first operation, her stomach never felt quite well, but now it did. Probably, the breaking down of the adhesions had relieved a tendency of the small intestine to be kinked occasionally at the site of the stenosis. The patient gained flesh rapidly, and is now—thirteen months after the second operation—a stout, strong, old lady.

The points of interest in the case are: (1) The occurrence of torsion of the small intestine without obvious cause, such as adhesions or malformation. (2) The recurrence of the torsion. (3) The length of intestine removed. (4) The lenteric diarrhoea, which for a time threatened the life of the patient. (5) The disappearance of the diarrhoea. (6) The appearance and disappearance of the exaggerated peristalsis.

McGavin, in Choyce and Beattie's "Surgery," states that a length of anything over three feet must be regarded as serious, although as much as eleven feet has been removed, and commends the use of spinal anæsthesia in those cases of strangulated hernia where resection may be required.

Kocher, in his "Operative Surgery," gives interesting figures as to resection of the small intestine, and quotes a report by Roux of a patient who survived with a small intestine only five feet long, and only half the length of the large intestine. He also quotes a report by Park of 12 recoveries in 16 cases of resection of more than six feet of bowel. In one of these cases over nine feet, and in another over ten feet were removed.

Moynihan, in his "Abdominal Operations," also quotes Park's report, and refers to the work of Senn and others, who studied extensive resections in animals, and noted diarrhoea and emaciation as sequelæ of such operation. Moynihan regards the length of bowel left as more important than the length removed, and calls attention to the great variation in the length of intestine in different subjects; but urges the free removal of bowel in all cases where doubt exists as to its integrity.

Maylard, in his "Problem and Practice in Abdominal Surgery," says, "As we exceed the six-foot limit, we begin to deprive the patient of parts requisite for the absorption of nourishment, so that the patient begins to emaciate, and this emaciation is independent of the quantity and quality of the food taken." He calls the condition "physiological starvation," and also refers to the danger of lenteric diarrhoea.

References to stenosis following resection of the bowel, and even compression, as in strangulated hernia, are frequent.

INTUSSUSCEPTION IN AN INFANT.

By Archibald B. Brockway, M.R.C.S. (Eng.), L.R.C.P. (Lond.)
Brisbane.

On April 4, 1915, I received a call to visit Mrs. A., whom I knew to be pregnant, but for whose confinement I had not been engaged. At her last confinement she had given birth to three girls, none of whom lived. When I reached the house at mid-day, I learned that I had been sent for to see the three-days' old baby girl, born a month prematurely. She had had no movement of the bowels since birth, despite some doses of castor-oil administered by the midwife. The babe was a puny child, and appeared to me to be at the point of death. The radial pulse was imperceptible, the respirations were faint, and accompanied by a feeble expiratory moan; there were dark patches under the eyes, and the skin about the mouth was almost black;

the corneal reflex was nearly absent; the abdomen was swollen, tense, darkly discoloured and knobby. The child had not taken the breast, and had subsisted on minute quantities of pump-drawn breast milk, given at irregular intervals. I expected to find an imperforate anus, but on examination, found a tense coil of small gut presenting. My little finger passed without difficulty into the rectum, pushing the gut before it, the latter returning as I drew my finger away. There seemed to me nothing helpful to be done. The child's condition was so serious that I believed she would be dead before I should have time to go home and return. I had only my midwifery bag with me, and even had I had the necessary instruments, I was convinced that the infant would not live through an operation for the relief of intussusception. Thinking that the release of the flatus in the bulging small intestine might possibly afford some relief, and also in consideration for the feelings of the parents, who would like to know that something had been done, using a hypodermic needle, I punctured the intestine. A quantity of odourless flatus was driven out, and the gut collapsed. Having done so much, I felt that there would be no harm in doing a little more. So, drawing down the intestine with a pair of pressure forceps, and borrowing a small table knife for the purpose, I excised a portion of the gut of about the size of my thumb-nail. There was no more bleeding than a stain. Telling the father that there was no hope for the baby's life, I left the house, wondering if I had rendered myself liable to an accusation of having performed a professionally criminal action, comforting myself with the knowledge that the parents were grateful to me for having "done something." On the following morning I called to express my sympathy, and was astonished to learn that the baby was alive and better. There had been a motion of meconium three hours after the operation, and though she had not taken the breast, the baby had seemed to enjoy the small quantities of pump-drawn breast milk which had been given to her, and had slept more peacefully. Her general condition was not so death-like as when I saw her first. Later, I learnt that during this day she took the breast, feebly at first, and then more naturally, and by the next morning, having passed a good night, was taking the breast quite well. She had had several apparently natural motions, and suffered from incontinence of feces, due, no doubt, to the forcible stretching of the *sphincter ani* by my finger. Her subsequent history was uneventful; she "slept, day and night, for a fortnight," the fecal incontinence ceasing in about ten days, and now, at the age of two months (I saw her this morning), she is, to all appearances, a normally healthy, though small baby.

Reviews.

ANOCI-ASSOCIATION.

Crile's work as a surgeon, and his researches into the nature, causes, and prevention of shock are so well known and have received such general recognition that any book written by him will certainly command attention. In collaboration with William E. Lower he has produced a work on anoci-association.¹ This work embodies the result of much experiment, and deals with practical deductions from them. The first part is devoted to a large extent to a consideration of the kinetic theory of shock, and to the theoretical basis of the principles of anoci-association. In the second part the practical application of the theoretical deductions are applied to the technique of surgical operations. The authors have set themselves the task of presenting, in the most practical manner possible, the technique of anoci-association. In this they have succeeded admirably.

The technique includes, *inter alia*, a preliminary hypodermic injection of morphine and bryonia, and a subsequent combination of local anaesthesia with light, general anaesthesia. The object aimed at is the avoidance of all shock, and they are prepared to sacrifice speed to gentleness. Moynihan, who has expressed himself in favour of this method, has emphasized the necessity of reducing shock to

a minimum, and has pointed out that speed should be the accomplishment, and not the aim of the operator. The authors have dealt in detail with the variations necessary for the application of shockless surgery to the various parts of the body. They apparently employ their specialized technique as a matter of routine. This practice will not meet with general approval. It is to be recommended in all cases in which serious shock may be anticipated. Though simple, it requires minute attention to detail. The slight increase in time involved is well compensated by the results obtained. We endorse all that the authors claim for their method.

Crile and Lower's work will appeal to the thoughtful surgeon. By its means the risk of a serious operation may be greatly reduced. No one engaged in the practice of surgery can afford to neglect this new branch of anaesthesia, and for this reason it is anticipated that the book will be found in every medical library; and that surgeons will peruse it carefully in order to enable them to become familiar with the essential details of anoci-association.

SURGICAL TUBERCULOSIS.

Dr. Fraser's experimental work¹ in connexion with bone and joint tuberculosis has become so well known, and his conclusions regarding the prevalence of bovine over other forms, so much discussed, that no introduction is needed to the author of the volume under review.

"Tuberculosis of the Bones and Joints in Children" is a book of some 300 odd pages, published in the Edinburgh Medical Series, in large, clear type, profusely and beautifully illustrated, and containing a most extensive bibliography and index.

It is dedicated to Mr. Harold Stiles, whose work it so obviously reflects, and to whom the author makes grateful thanks. The volume is divided into two portions, a consideration of the disease from the general aspect, and an investigation of it as it appears in individual regions. It is undoubtedly the best publication upon the subject yet issued in English, and is most exhaustive in dealing with every phase from an anatomical, bacteriological and pathological point of view, through the various clinical stages to treatment. It is interesting to view the author's mode of attacking the treatment of bone and joint tubercle in children. No parochial considerations have been allowed to bias his judgement in favour of radical as against conservative methods, and an equally clear exposition of both is given.

Notes on Books.

SCIENTIFIC RESEARCH IN NEW SOUTH WALES.

The Honorary Secretaries of the Royal Society of New South Wales have edited for publication the papers² read at the meetings held during October, November and December, 1914. Sixteen papers were read at these three meetings. In zoology, Dr. J. B. Cleland continued his description of the hæmatozoa of Australian Batrachians, and Mr. Briggs communicated some notes on Tasmanian hydroids. Botanical papers were prepared by Messrs Maiden, Cambage, Baker, Cheel and Cleland. Mr. Radcliff dealt briefly with the recovery of actinium and ionium from clary ores. The praiseworthy investigations of Mr. Radcliff should be of special interest to medical men in Australia, as they have lead to the production, under his direction, of radium from Australian ores. This radium is for sale in Sydney. Professor Robinson and Mr. H. G. Smith have commenced the study of the constitution of the substances isolated by Mr. Smith from the indigenous plants of this continent. Mr. Knibbs has published a contribution to the theory of statistics in conjunction with Mr. Barford, of the Commonwealth Bureau of Statistics. Mr. E. P. Taylor gives some useful information on the distribution of frictional losses in internal combustion engines. Some parts of this paper

¹ Anoci-association, by George W. Crile, M.D., and William E. Lower, M.D.; Edited by Amy F. Rowland, 1915. Philadelphia and London: W. B. Saunders, Company; Demy 8vo., pp. 259. Price, 15s.

² Bones and Joint Tuberculosis of Children, by J. Fraser, M.D., F.R.C.S.E., Ch.M., 1914. Edinburgh: Adam & Charles Black (Edinburgh Medical Series).

³ Journal and Proceedings of the Royal Society of New South Wales, Vol. XLVIII., Part III, and Part IV., Demy 8vo.; Part III., pp. 289-520, containing six plates; Part IV., pp. 22, containing Abstract of Proceedings, Title Page, Contents, List of Publications, List of Members, etc., and Index.

should be of interest to those with motors and oil-engines. Mr. H. B. Taylor has dealt with the kinetics of the catalase reaction in milk. Incidentally, he has put forward the view that the catalase in milk is derived from bacterial contamination of the milk. A similar view has been enunciated in regard to the peroxidase of milk, but has been recently shown to be erroneous. Dr. Chapman describes some of the pitfalls for the analyst in the estimation of the amount of fats in foods for consumption by infants.

Hospitals.

QUEEN'S MEMORIAL INFECTIOUS DISEASES HOSPITAL, FAIRFIELD.

A meeting of the Board of the Queen's Memorial Infectious Diseases Hospital, Fairfield, was held on June 16, 1915, for the purpose of considering the recommendation of a sub-committee in regard to the improvements suggested. It was determined that the isolating block in course of erection should be furnished and equipped. A discharge block is to be erected, and is to contain a waiting-room for the parents of patients. Three fresh wards are to be erected—one for scarlet fever, on two floors, with provision for 20 beds on each floor, one for measles, with provision for 24 beds and separation of the sexes, and one for diphtheria, provided that an isolation home for carriers is not determined on. Additional accommodation is to be provided for nurses, the home to be able to take 60 nurses at first, and to be capable of extension to accommodate 100 at some future date. The Board determined to defray the cost of the installation of the sewerage in instalments. In addition, a shelter-shed for visitors and patients is to be erected, and various improvements are to be provided. The Board resolved that the Minister be interviewed for the purpose of obtaining financial assistance in connexion with the work. It was agreed that the improvements and additions referred to above should only be carried out if power were granted to the Board to borrow the necessary money.

THE KYNETON DISTRICT HOSPITAL.

A certain amount of difficulty has arisen at Kyneton in connexion with the staff of the hospital. It appears that Dr. J. Horace Downing, who has been associated with the hospital for some little time, has volunteered for service abroad and has been accepted. Dr. Downing made arrangements with the Resident Surgeon, Dr. Mary Lane, to act as his *locum tenens* during his absence. Dr. Lane agreed to do so, on the understanding that the Honorary Medical Officers of the hospital would assist her in her hospital work. She therefore wrote to the Hospital Board, asking for permission. The members of the medical profession in Kyneton have shown a patriotic spirit in arranging to carry out any additional work which may become necessary as the result of one of them going to the front. The letter written by Dr. Lane was subject to considerable discussion at a meeting of the Board, held on June 11, 1915. The President took the view that the permission should not be granted Dr. Mary Lane to act as Dr. Horace Downing's *locum tenens*, on the ground that the hospital patients would suffer under this arrangement. In spite of the assurances given that the members of the honorary staff would assist the resident surgeon, and would not allow any neglect to take place, he succeeded in inducing several members of the Board to vote against the permission being given. We are pleased to state that the motion was carried in spite of this opposition. It appears as if the ranks of the medical profession will be thinned very considerably in the response to the call for more doctors for military service, and if hospital boards raise difficulties where none need exist trouble will be sure to ensue.

HOME FOR INCURABLES, SOUTH AUSTRALIA.

The annual meeting of the Home for Incurables, of South Australia, was held in Malvern on April 21, 1915, Lady Galway presided.

In moving the adoption of the report and balance-sheet, Mr. G. F. Claridge, the Chairman of the Committee, stated that in spite of the unpropitious time the home had had a

successful year. After making some appreciative remarks on the valuable services rendered by the late matron, and having referred to the confidence and esteem in which the new matron was held, he turned to the question of finance. The Government had been generous in the past, but he did not propose at present to ask for any special aid. Last year he had announced that a gentleman who had died had left the whole of his estate of £20,000 to the Home. They had not yet come into possession of it. This year he had to announce that another gentleman had left the whole of his estate, valued at £6,900, to the institution. Other sums had been left to them. It was proposed to make additions to the Home, at a cost of about £1000.

The Chief Secretary referred to the fact that the Government subsidy amounted to £1250, and expressed satisfaction at the prosperous condition of the Home. It would be necessary for the Government to provide £17,765 to the various charities during the year.

In the annual report it is announced that during the year ending March 31, 1915, 46 patients had been admitted, 31 had died, and 13 had left the Home. There were 130 patients in the Home at the end of the year. The excellent work carried out in the Home is dealt with briefly in the report.

In the financial statement the expenditure is shown to have amounted to £4,345, and the sum of £1,250 was transferred to the endowment accounts. On the other side the income was made up of the Government subsidy, receipts for inmates' maintenance, amounting to approximately £1,376, bequests, donations, etc., to the amount of £1,276, endowments amounted to £1,250, and other sundry receipts, leaving an excess of expenditure over income of £11 2s. 5d.

CHILDREN'S HOSPITAL, PERTH.

It is reported that the sum of £1,910 18s. 1d. has been collected since the end of June toward the maintenance fund of £3,000 asked for by the committee of the hospital. Attention has already been drawn to the fact that unless this amount is forthcoming within a comparatively short time, some of the wards will have to be closed, to the great injury of the sick children of Perth. It will be remembered that Mr. Boan promised a donation of £500 on the condition that the balance, *viz.*, £2,500 was forthcoming. A little more than £500 is now required, and we hope that this sum will be presented to the committee during the present month.

MATERNITY BONUSES.

According to the official returns, no less than 10,997 £5 bonuses were paid to mothers in respect to their confinements during the month of June. The total number of claims paid up to date is 355,349, while 1,964 claims have been refused and 1,226 are still under consideration. The Act has therefore cost the community over 1¼ million pounds sterling since it passed into law. The number of prosecutions for fraudulent claims is not inconsiderable, and we assume that a larger number of successful fraudulent claims are made without discovery. But these cases cannot affect the total sum payable to a material degree. The proportion of women claiming the bonus is extremely high, and indicates that many who cannot need the advantage are claiming it.

The Honorary Treasurers of the "Medical Women and the Wives and the Sisters of Medical Men of New South Wales" have received just under £500 up to date. It is hoped that £1,000 will be collected. The first instalment has been sent through the Red Cross by cable. Further subscriptions are being sought, the minimum amount being £1 1s. A meeting will be held at the B.M.A. Rooms, 30-34 Elizabeth Street, Sydney, on July 23, 1915.

Correction.

In the issue of July 10, 1915, an article on "Surgical Disorders in Infancy and Childhood in General Practice," by Dr. E. H. Binney was published. Dr. Binney is there described as an Honorary Surgeon at the Royal Prince Alfred Hospital. This should have been Honorary Surgeon at the Royal Alexandra Hospital for Children.

The Medical Journal of Australia.

SATURDAY, JULY 17, 1915.

The Pharmacology of New Preparations.

Some few years ago an attempt was made in Europe to regulate the testing of the pharmacological action of new drugs and preparations by setting up certain rules to be followed by those interested in this matter. It was felt that the practice of some manufacturers to offer handsome fees to medical practitioners and pharmacologists for favourable reports on new preparations was getting very common, and that in many instances these tempting prizes were accepted and reports given when the preparations were not worthy of favourable notice. In order to place the testing of new drugs and preparations on a sound basis, a scheme was evolved whereby the manufacturing chemists would submit their products to recognized pharmacological laboratories for investigation. The fees to be paid for the work would go to the laboratories, and the Director or Professor in charge would be responsible for the proper conduct of the investigations. The work would be carried out by trained assistants or by the principals, but in no instance would the fee be dependent on the nature of the report, and, furthermore, in no instance would the individual conducting the investigation receive the fee for himself. The workers in the laboratory would be paid by the laboratory, and there would be no hardship in requiring them to carry out this class of work without further fee. In regard to the clinical examination of the value of drugs previously tested in the laboratory, it was determined that no fee should be paid, and that physicians should be asked by the head of the pharmacological laboratory to try new preparations which appeared to the latter to be worthy of a clinical trial. Since this would be done in ordinary hospital practice, and since no extra work would be entailed, it was felt that no fee should be asked for, but if a report were required, an honorarium or donation could be given to the institution at which the observations were carried out. The principals of some of the large manufacturing firms of chemists welcomed this plan,

and promised it their whole-hearted support, but difficulty was met with in regard to some of the professors of pharmacology. The necessity of some arrangement was recognized at the meeting of *L'Association Internationale de la Presse Médicale*, held in Budapest in 1908, at the same time as the International Congress of Medicine. But, even then, the difficulties of giving practical effect to a scheme was realized.

A peculiarly striking demonstration for the necessity of regulating the reports on new preparations is instanced in the work of Ribemont-Dessaignes and his, or rather Paulin's, detoxicated morphine or *tocanaline*. At first, the advantages of the new preparations could not be spoken of too highly. The discovery was to revolutionize obstetric practice. Within a very short space of time, we learned that Ribemont-Dessaignes had given up the use of this preparation altogether, and had come to the conclusion that Paulin had not proved the contention that the morphine had been rendered non-toxic. The French *savant* returned to morphine pure and simple, given together with strychnine and caffeine. Why these drugs should be given is not clear. The combination of morphine and strychnine is certainly not a happy one from a pharmacological point of view. The dose of morphine given was said to be 1 c.cm. of a 3.34% solution, which is equal to about 0.03 grams, or approximately $\frac{1}{2}$ grain. With this large dose he now claims to effect a saving of pain and an increase of safety. He also claims that while labour is arrested by 1 c.cm. of 1% of morphine, this is not so with a dose of the 3.24% solution. It is well known that morphine does not exert any action on unstriated muscle at all. The effect of the smaller dose on the puerperal woman would be to lessen the perception of the pain, and to diminish the desire to assist in bearing down. This exclusion or partial exclusion of voluntary muscular action in assisting the uterine contractions may be useful at times, but is a great disadvantage in many labours. The deeper the narcosis, the less the woman would be in a position to assist. We are therefore at a loss to understand Ribemont-Dessaignes's contention that the larger dose interferes less with the course of the labour than the smaller one. The deductions which we feel justified in making from

this small and somewhat unimportant episode in obstetric history is that the great discovery is not an improvement on the morphine-scopolamine *Dämmerschlaf*, which, in selected cases, is very valuable; that Ribemont-Dessaignes made a mistake, and, in trying to rectify it, has made two further blunders, in combining strychnine with morphine, and in asserting that large doses of morphine exercise less effect on labour than moderate doses, and, lastly, that there is great need for the proper regulation of the testing of new pharmaceutical preparations.

THE SUPPLY OF MILK TO SYDNEY.

When micro-organisms enter into milk they multiply freely under favourable conditions. The sugar of milk is a medium for the development of microbes producing various acids from the sugar; the curd favours the growth of germs that give rise to putrefaction in the proteins and the fat of milk serves as food for moulds. Pasteur pointed out that bacteria initiated chemical changes in the liquids and solids in which they grew, and he suggested that bacteria might be classified according to the chemical changes that they occasioned. The development of micro-organisms in milk leads to the formation of acids which render the milk sour, to the production of harmful substances that make it unwholesome when taken in sufficient quantities, and to the loss of nutritive qualities, due to the destruction of foodstuffs. In the absence of bacteria, milk undergoes no alteration. When obtained from a clean cow in clean vessels, milk is free from germs. Such milk keeps indefinitely. When few germs are present, milk alters slowly. The chemical changes in milk proceed at a rate dependent on the number of microbes present and the amounts of lactic acid and other products of bacterial activity increase *pari passu* with the multiplication of the germs leading to their formation. These facts form the basis on which all means for keeping milk are founded.

Sydney receives its supply of milk from metropolitan and country sources, one-third from the dairies of the suburban area, and two-thirds from farms in districts extending out one hundred and fifty miles from the city. About fifty thousand gallons are required for each day's service. This allows a daily consumption of one pint per head of the

population. The milk from the metropolitan area is conveyed to the consumer within a few hours of milking, but the milk from the districts outside Sydney is not delivered until it is twenty-four hours old. Experiments made in the physiological laboratory of the University of Sydney have demonstrated that clean, untreated milk, kept under ordinary conditions, began to sour in twelve hours. The distributing companies employ special means to preserve the country supply until it reaches the consumer. A portion of the milk is cooled in the country and carried to Sydney in large tanks. The remainder is conveyed in cans without any special care. This milk is pasteurized in Sydney.

The rate of development of organisms in milk is regulated by the temperature. The results of some experiments on fifteen samples of milk are instructive on this question. Milk containing 6,000 bacteria per cubic centimetre showed no increased number of germs when kept at 40° F. for 48 hours; similar milk kept at 55° F. showed the same number of organisms in 32 hours, but the organisms were five times as numerous in 48 hours; and when the milk was kept at 70° F. the same number of germs were present after 12 hours, five times as many after 15 hours, one hundred times as many after 24 hours, and one thousand times as many after 32 hours. Large quantities of milk maintain a low temperature for many hours. Milk in tanks containing three thousand gallons and cooled to 40° F. is only heated two degrees during a railway journey of eight hours, even when the cars are not specially constructed to avoid heating the contents.

It can be asserted that the carriage of cooled milk in bulk solves the problem of its transport over considerable distances. American hygienists teach that the maintenance of a low temperature is a more significant factor in keeping milk than any other connected with dairying. When the dairyman cools milk at once and maintains a constant temperature of 50° F. or less, he can supply milk of superior keeping quality, and he is safeguarded against loss. Modern methods of making ice allow of its production, even in small amounts, at very cheap rates. Hence the cold water now considered ample for cooling the milk should be reinforced with ice. When the former has cooled his milk he should

wrap his cans in a blanket and carry them in a covered waggon to the collecting station. Near the railway stations in the country the milk should be cooled again before being placed in the cars. Refrigerator cars are not needed when the milk is carried in bulk.

The producer can thus be instrumental in improving the conditions of transportation, so that the multiplication of bacteria during transit may be reduced to a minimum. The handling of milk subsequent to its arrival in Sydney is beyond his control. In justice to him the distributing companies and retailers should exercise such care that the number of bacteria in milk does not increase rapidly through carelessness in distribution. Much can be done to improve the milk supply by enlightened public sentiment, by a public-spirited attitude of medical organizations, and by liberality on behalf of the consumer.

WAR—AND WHAT IT MEANS.

Men are apt to be silent after they have tasted the bitter bread of battle. The horrors shatter the nerves of many, rob not a few of reason for a time or permanently, and create in all a sense of revulsion and an instinct of desperation, which is difficult to describe and wholly impossible to measure with anything approaching accuracy. In Flanders, many men have become amnesic, aphasic and deaf; many have shown a variety of symptoms of mental disturbance and other nervous lesions. In the Gallipoli Peninsula, these brain and nerve effects have not been wanting, and yet it is unlikely that full accounts of the fearful effects of shell and shrapnel have been described by anyone. The following pathetic sentences, culled from a letter written by Dr. A. H. Tebbutt to an intimate friend, though brief, are replete with suggestion. They are of enhanced interest in the reference to the wounding and death of Dr. Muir Smith, whose heroism is eloquently described in the few words. Dr. Tebbutt wrote: "Just a word whilst rifle crack and cannon's roar in our shrapnel proof Br. headquarters ten yards behind the trenches. I have been through so much during the past four weeks that I do not feel up to giving you any details. If I get through this campaign I will tell you some stories in happier days. There's just this—the horrors of war are worse than can be imagined. What I am writing for is to tell you, so that you can tell the fellows, that poor Muir showed great heroism, and we are all very proud of his memory. Though shot in the leg, he struggled on and on, though advised to go back, and when we retired he struggled back gamely, only to fall before the trench was reached. . . .

" I am proud of the way our Australian boys have fought. You may all be proud

of them. They count their scalps in the trenches, and love the Turks to charge, and we never feel doubtful of their morale at all. When wounded, they never complain. They just want a cigarette, and they grin and bear it then. I have the "flue," and am very stale, tired and dirty.

" Good luck to you, and remember me to all the boys. God save the King. Yours, A.H.T."

The letter was written on a dirty scrap of paper, soiled, like the writer, by the grime of the battlefield, but written by a man whose courage and self-sacrifice must command our gratitude and respect.

THE CASE OF DR. SCHLINK.

On July 7, 1915, the Assistant Minister for Defence made a statement in regard to the condition of the Liverpool training camp and the various allegations made in the House of Representatives by Mr. Orchard. Prior to this statement, the Prime Minister announced that he had asked the Attorney-General to appoint a Judge of the High Court to enquire into the charges made. In the course of his speech, the Assistant Minister stated that the medical arrangements at the camp were complete and entirely satisfactory. He has taken up the defence of Dr. Schlink, and has satisfied that officer in his reference to the charges made against him. As a result of the statements made in the House, Captain Schlink has sent in his resignation as Senior Medical Officer at the Liverpool Camp.

Mr. Justice Rich was appointed on July 12, 1915, to make enquiry into the statements and charges as they appear in "Hansard." The reference gives him a free hand to conduct his enquiry as he deems best. It is anticipated that the investigation will begin forthwith.

In view of the fact that an enquiry into the charges made by Mr. Orchard is to be held, and we hope to be held soon, and further since the charges were of a very serious nature, we are of opinion that Dr. Schlink has erred in taking this step. Nevertheless, it is anticipated that every point dealing with his medical administration and with his action as the responsible medical officer at the camp will be subjected to a searching enquiry, in order that no one can entertain any suspicion that Captain Schlink failed in his duty. As stated last week, we have enquired carefully into the charges made, and do not hesitate in condemning them one and all as devoid of foundation and quite untrue. Even if his resignation be a little premature, he will be in a position to emphasize in public the replies to each and every charge made, and thus to leave a permanent record of his honour in the annals of the country he is serving at no small sacrifice.

HUMAN TEMPERATURES IN THE TROPICS.

Many observations have been made in different parts of the world to ascertain whether the mean body temperature of Europeans living in tropical countries is different from that which is found in temperate climates. The results published by various investigators do not agree together. The majority state that the effect of tropical heat is to

raise the mean temperature of the body of Europeans by a small amount, usually less than one degree Fahr. On the other hand, there are many who declare that they have found no indication that the temperature of the body is any higher in the tropics than in Europe. These conflicting statements can be attributed to the conditions under which the temperatures were observed. In most cases the temperatures were taken in the mouth or in the axilla and only in a few cases in the rectum, as most observers have assumed that, in a moist and warm climate, the temperature in the mouth can be taken as a reliable index to the temperature of the body. The figures recorded by Dr. W. J. Young* on the temperatures observed in the mouth, rectum, and, in some cases, the urine of six white men living at Townsville, North Queensland, show that this is not correct, and that observations taken in the mouth alone lead to erroneous conclusions.

The rectal temperatures have been always higher than those of the mouth, the difference varying in different individuals. On waking in the morning, the difference between the average of the mouth and the rectum has been more than 1° F., while, after exercise, the difference has amounted in certain subjects to as much as 3° F. During complete rest, the rectal temperatures have not shown any marked variations from the limits observed in Europe. Slight muscular work raises the rectal temperature, and this raised temperature is maintained for some time after the work ceases. The author ascribes the increased rectal temperatures entirely to muscular exercise. The average diurnal variation lay in four individuals between 1.7° and 2.0° F. for the oral and between 2.1° and 2.8° F. for the rectal temperatures, while in a fifth person the variations were 1.3° and 1.4° F. respectively. These observations were made at the Australian Institute for Tropical Medicine on members of the staff.

THE SCHEME FOR ATTENDANCE ON THE WOUNDED.

The following letter has been addressed by the Director-General of Medical Services to the Honorary Secretaries of the six Branches of the British Medical Association in Australia:—

After consulting with several leading medical members of the Association in various States, a scheme was drawn up by the Acting Director-General of Medical Services. It was approved by the Minister for Defence, and was ready to be sent to Branches, with a request for their consideration and suggestions, when a special meeting of the Federal Committee was called to deal with the subject of organizing the medical profession in Australia for the purpose of the war.

This scheme was held back until the opinions of the members of that Committee and others at that Conference could be obtained. It was favourably received by that Committee.

The day after the Federal Committee had concluded its business, the Director-General of Medical Services was informed that privileges of returned and other invalids enlisted for the war had been altered. Under these circumstances, the scheme was temporarily withdrawn, and is now forwarded with the request that it may be considered by your Branch.

At the time the original scheme was drawn up, it was understood that invalids were entitled to pay and medical attendance for three months in most cases, and for six months in a smaller number, after their return to Aus-

tralia, so that provision was made for medical attendance for only six months, and a small fee was suggested as the length of attendance was limited.

This has now been altered, and medical attendance may, in some cases extend over a longer period, but this scheme is strictly limited to six months. At the end of that time, other arrangements will be made.

The word "invalid" is to be taken to mean all classes of sick or wounded soldiers, as explained in the original scheme.

Out-patient departments will be arranged at all military hospitals, so the scheme will only apply where no such hospital is established.

In making arrangements for the care of all invalid soldiers returned to Australia, it is desired that those able to leave hospital should be allowed to return to their homes as soon as they are fit to do so. They are entitled to medical attendance and medicine at the expense of the Department.

Needless to say, if they are allowed to go all over Australia and consult medical men as often as they choose, great confusion will arise, and it will not be possible in any way to check accounts and charges or obtain reliable information as to the question of invalids.

As soon as the medical officers at hospital consider soldiers are fit, they will be allowed to go to their homes. It is desired, should they require further medical attendance, that they will be able to obtain the best available, and that the medical attendant will be in a position to obtain any particulars of the case available.

It is not desired that they should receive gratuitous or charitable medical attendance.

State of health on discharge will be no worse, probably better in most cases, than that of patients leaving a public hospital. Any soldier becoming worse or seriously ill will be taken back into a military hospital, or, if more convenient, into a public hospital, at the expense of the Department.

The carrying out of all arrangements will be in the hands of the Principal Medical Officer in each State, and all matters arising out of the subject will be controlled by him, subject to the instructions of the Director-General of Medical Services.

I shall be pleased if you will ask the members of the Branch to consider the proposals, and inform me of the result of their deliberation, together with any suggestions they may desire to make upon the subject.

As this is the first opportunity that has been given to the profession in Australia to formulate and carry out a large, comprehensive scheme of medical attendance through their own Association, and practically controlled by medical men, it is hoped that Branches may see their way to accept the proposals, and that the officers of the Branch will assist the Department to overcome any little difficulty that may arise, and in making the scheme a success.

[Enclosure.]

Medical Attendance Upon Soldiers Enlisted for Active Service After Discharge from Hospital in Country and Other Districts where no Military Hospital is Established.

All soldiers on leaving hospital and proceeding to a district in which no military hospital is established, to be given a card with short particulars of case, and name of medical man where he is going to reside. If more than one medical man in a town, they will be allotted, as far as possible, in rotation to all medical men (subject to a free choice by soldiers).

On production of that card, the medical man will be liable to attend the soldier at soldier's residence or at the doctor's consulting rooms, for a period not to exceed six months, and also to arrange for a supply of medicine and dressings. Provided he shall not be compelled to travel more than two miles from his consulting rooms to make such visits, and also that, should the soldier become seriously ill or require special attendance, he may be returned to military hospital or other hospital as directed. For fresh injury or other new disease the soldier is not entitled to attendance by Department.

Medical men will be liable to supply reports, if required, on the condition of any soldier.

For that service it is proposed to pay the sum of 25s. for six months for each soldier placed in medical

* Journal of Physiology, xlix., p. 222, 1915.

man's list, to cover cost of medical attendance and medicine; names, of course, being supplied to medical men when soldier leaves hospital.

Naval and Military News.

The following notice has appeared in the Commonwealth Government Gazette, No. 71, under date of July 10, 1915:—

Formation of New Units.

His Excellency the Governor-General, acting with the advice of the Federal Executive Council, has been pleased to approve of the following new units of the Militia Forces being raised, as specified in the attached table, to come into operation on and from 1st July, 1915:—

Militia Forces.

1st Military District.

A.A.M.C.—

- 3rd Australian Army Medical Corps (Field Ambulance).
- 34th Australian Army Medical Corps (Company).

2nd Military District.

A.A.M.C.—

- 9th Australian Army Medical Corps (Field Ambulance).
- 10th Australian Army Medical Corps (Field Ambulance).
- 11th Australian Army Medical Corps (Field Ambulance).
- 39th Australian Army Medical Corps (Company).

3rd Military District.

A.A.M.C.—

- 12th Australian Army Medical Corps (Field Ambulance).
- 15th Australian Army Medical Corps (Field Ambulance).
- 49th Australian Army Medical Corps (Company).

4th Military District.

A.A.M.C.—

- 20th Australian Army Medical Corps (Field Ambulance).

5th Military District.

A.A.M.C.—

- 53rd Australian Army Medical Corps (Company).

6th Military District.

A.A.M.C.—

- 54th Australian Army Medical Corps (Company).

It is with great regret that we have to announce that Colonel C. S. Ryan, of Collins Street, Melbourne, attached to the Divisional Staff of the A.I.F., is reported to be dangerously ill. Colonel Ryan was previously reported ill.

The following casualties among the members of the R.A.M.C. have been reported from France and Belgium:—

Killed: Lieutenant G. H. Lunan, M.B., Ch.B. (Ed.), R.A.M.C., of Edinburgh; Lieutenant G. M. Chapman, M.B. (Cantab.), R.A.M.C., son of Mr. Justice Chapman, of Auckland, New Zealand. Lieutenant Chapman was attached to the 2nd Dragoon Guards, and was killed on May 13, 1915. He was previously house surgeon at the London Hospital.

Died of Wounds: Lieutenant J. A. MacMahon, M.B., Ch.B., B.A.O. (Dub.), of Howth, county Dublin, R.A.M.C. (previously reported wounded, *The Medical Journal of Australia*, July 3, 1915).

Wounded: Captain H. S. Hollis, M.B., B.S. (Lond.), M.R.C.S., L.R.C.P., R.A.M.C. (T.F.), of Hove, near Brighton; Lieutenant W. Kelsey-Fry, M.R.C.S., L.R.C.P., R.A.M.C., of Blackheath, London, S.E.; Captain H. Forbes Pantom, M.B., Ch.B. (Ed.), R.A.M.C., of Edgbaston, Birmingham; Lieutenant William T. Quinlan, M.R.C.S., L.R.C.P., R.A.M.C., of Brighton; Lieutenant W. A. Stewart, M.B., Ch.B. (Glas.), R.A.M.C.; Lieutenant David G. Watson, M.B., Ch.B. (Ed.), R.A.M.C., of Edinburgh.

Suffering from Gas Poisoning: Lieutenant P. W. James, M.D. (Durh.), M.R.C.S., L.R.C.P., R.A.M.C., of Croydon.

The following member of the Canadian Army Medical Corps is reported as having died of wounds: Captain G. C. Glidden, attached to the 10th Batt., Western Canada Regt. The following are reported wounded: Captain F. C. Bell and Major G. S. Mothersill, both of the Canadian Army Medical Corps.

Surgeon Probationer William W. K. Brown, R.N.V.R., of H.M.S. *Maori*, who was previously reported missing, is now reported prisoner of war.

The following has appeared in the District Orders (No. 2 Military District), No. 64:—

2nd Military District.

A.A.M.C.—

Lieutenant-Colonel A. E. Perkins, D.S.O., to be Principal Medical Officer (temporarily), with pay, consolidated, at rate of £500 per annum, *vice* Colonel T. H. Flaschi, D.S.O., V.D., seconded from the appointed for duty with the Australian Imperial Expeditionary Force.

Benjamin Digby Gibson to be Captain (provisionally and temporarily).

Second Lieutenant R. B. North is transferred from Sydney University Scouts, and to be Captain (provisionally and temporarily).

A.A.M.C. Reserve—

Gilbert Elliott Aitken to be Honorary Captain.

Lieutenant J. H. Bradley is transferred from Australian Volunteer Automobile Corps, and to be Honorary Lieutenant.

It has been announced that Dr. Paget, A.A.M.C., has been appointed chief surgeon at a base hospital in France.

Dr. D. G. Robertson, Federal Quarantine Officer for Victoria, has been appointed Captain in the A.A.M.C.

The following notice has appeared in the Commonwealth Gazette, No. 67, under date of July 3, 1915:—

MILITARY FORCES OF THE COMMONWEALTH.

District Principal Medical Officers.

His Excellency the Governor-General, acting with the advice of the Federal Executive Council, has been pleased to approve of an allowance being paid, during the war, to the Officer performing the duties of Principal Medical Officer in each Military District as under, to take effect from 1st July, 1915:—

- 1st Military District—£500 per annum.
- 2nd Military District—£600 per annum.
- 3rd Military District—£600 per annum.
- 4th Military District—£500 per annum.
- 5th Military District—£350 per annum.
- 6th Military District—£250 per annum.

It has been announced in Melbourne that arrangements are to be made for the equipment of hospitals and convalescent homes throughout the Commonwealth, to contain 4,100. There will be 1,500 in Victoria, of which nearly 700 will be situated at a base hospital in St. Kilda Road, Melbourne. New South Wales will have 1,000 beds, including close on 600 at the Randwick Asylum. In South Australia there will be 500 beds, 350 of which will be in the Keswick Barracks and Blind Asylum, while the convalescent home which Mr. Barr Smith is placing at the disposal of the Department will accommodate 150 patients. A further 500 beds will be situated in Western Australia, and will include the hospital in Fremantle for 100 patients. There will be 500 beds distributed in various homes in Queensland and 100 beds in Tasmania. Other hospitals may be erected by the Department in the neighbourhood of Melbourne or Sydney.

The Council of the Victorian Branch has issued a circular to the members of the Branch, enclosing a form to be filled in (see *The Medical Journal of Australia*, July 3, 1915, p. 22), and a pamphlet, appended below. The members are reminded that there will be no arbitrary restrictions as regard age for service in the Australian Army Medical Corps, provided that there is physical fitness. The Council offer their services in making arrangements for the carrying on of the practices of men who accept service.

Conditions of Service.

The following information has been supplied by the Director-General of Medical Services:—
Imperial Forces.

Rank: Lieutenant.

Pay: 24s. per day inclusive.

Privileges: First-class passage to and from England. Bonus, £60 at end of service, if entirely satisfactory.

Term: 12 months, or the duration of the war if less than 12 months.

Uniform Allowance: £37 10s.

(Continued on page 60.)

Abstracts from Current Medical Literature.

SURGERY.

(23) Acholuric Jaundice.

Harold Upcott (*Brit. Journ. of Surgery*, April, 1915) reports a case of familial acholuric jaundice, which was greatly relieved by splenectomy, and reviews the literature of splenic jaundice. The condition is characterized by chronic jaundice, anaemia, enlarged spleen and excess of urobilin in the urine and faeces. All these symptoms are liable to periodical exacerbations. The jaundice usually commences in childhood, being slight in degree and peculiar in that no pruritus nor bradycardia is noted, and no bile salts are present in the urine. In addition to these signs, the patients complain of weakness, languor, loss of appetite, nausea, headache, epigastric pains, and more rarely of pain in the region of the spleen. The blood changes are definite. The haemoglobin and the number of red cells are diminished; the latter show granular degeneration, polychromatophilia and increased fragility. There is a distinct leucocytosis, in contrast to splenic anaemia. The spleen is much enlarged, and there is evidence of perisplenitis. Microscopical examination reveals a diffuse fibrosis. Arguing from the work of Städleimann, Afanasien and Hunter, he concludes that the condition is a hæmohepatogenous jaundice, the seat of the hæmolysis being the spleen. He points out that the beneficial results of splenectomy support this view. After the operation, the jaundice generally fades in a few days; a period of increased leucocytosis follows, but the anaemia disappears more gradually.

(24) Traumatic Cerebral Lesions.

In discussing the subject of renewing traumatic cerebral lesions, Trotter (*Brit. Journ. of Surgery*, April, 1915) points out that the brain is enclosed in an inextensible cranio-dural capsule, and that it followed that any swelling of the brain or intrusion of a foreign body must cause a corresponding displacement of the normal cranial contents (brain, intracranial vessels and cerebro-spinal fluid). Traumatic cerebral injuries may re-act in three ways; (a) by interference with the cerebral circulation, (b) by direct injury to the brain, and (c) by reactionary swelling or oedema. The cerebral circulation may be interfered with by two different sets of forces. The first consists of the vital forces of the patient, producing oedema, hæmorrhage, inflammation or tumours. This interference yields the clinical picture of compression. Hæmorrhage, whether intracerebral, intradural or extradural, tends to lead to interference with the circulation of the adjacent parts of the brain. The local changes in the circulation take place in three distinct stages. (i.) The stage of compensation, in which there is a local displacement of cerebro-

spinal fluid and no disturbance of the circulation; (ii.) the stage of venous obstruction, in which there is an arrest of the escape of venous blood from the vessels, leading to a condition of stasis, and manifested by an increased excitability of the cerebral tissue; and (iii.) the stage of capillary anaemia, in which the pressure has increased and causes collapse of the capillaries, leading to a loss of function of the affected part. The second set of forces act in cases in which external violence has caused the injury. The violence in these cases excites pressures, usually not more than momentary, enormously greater than the arterial pressure. When the force is distributed over a considerable area of the skull, a temporary inbending of bone is caused and the more the skull departs from its spherical form, the greater is the diminution of the intracranial space. A similar condition occurs when a bullet of sub-maximal velocity perforates the skull. In this case, the force acts with extreme rapidity, and is conducted through the whole skull, owing to the inertia of the fluid contents. The whole brain is compressed, like a sponge being squeezed out. This sudden compression leads to a momentary capillary anaemia, which corresponds clinically to compression. It tends to pass off spontaneously, but complete restoration of the circulation is slow, since anaemia of the bulb leads to a fall of blood pressure.

When reactionary swelling or oedema results from direct injury to the brain, the deformation of the skull may produce damage to the brain by a temporary indentation of the skull leading to the bruising of the brain, or a concussion may occur by contracoup or the brain may be damaged by stress and distortion between the two poles. Again the intrusion of a modern bullet through the skull may give rise to various effects. The intracranial contents behave as a continuous homogeneous medium filling the skull, and the energy of the bullet may be transmitted throughout the skull, against the inner surface of which enormous pressure may be brought to bear. The cranial vault may be shattered, the scalp torn open, and there may be more or less complete disorganization of the brain. The transmission of energy of the bullet decreases with the distance travelled and the diminished velocity. When external violence is applied to the skull over a small area, the inbending of the bone is abrupt and a local fracture occurs. The depressed fragments cause confusion and laceration of brain substance, but no polar or concussion symptoms occur.

The author proceeds to consider the effect of reactionary swelling or oedema. Contusion and laceration of the brain lead to oedema, and this increases the pressure on the neighbouring veins. The exudation is produced from the damaged capillaries, and, consequently, the pressure cannot exceed the capillary pressure. A capillary anaemia will, therefore, not be produced. The symptoms are recognizable in mild degrees of swelling in

the type known as the period of reaction, and in the more severe degrees as cerebral irritation. From a clinical point of view, head injuries may be grouped as follows: Grave cases with widespread compression of the hemisphere, due to extradural, subdural or intracerebral hæmorrhage; and grave cases with coma without localizing signs. In the latter the only change found post mortem is increase of cerebral tension. In the next place, there are cases with irritative signs, associated with marked mental symptoms due to extensive subdural hæmorrhage, or with cerebral symptoms due to oedema, or with early focal signs, leading to Jacksonian epilepsy, due to cortical hæmorrhage. There are also cases with signs of localized cerebral lesion, but no evidence of a wide spread disturbance due to cortical hæmorrhage, and, lastly, cases of localized injury of the skull and brain, due to direct violence as in compound depressed fractures.

(25) Thoraco-plastic.

H. Morriston Davies (*Brit. Journ. of Surgery*, April, 1915) has performed an operation of mobilizing the ribs in order to produce collapse of the lung in two cases of pulmonary tuberculosis. It had been found impossible to induce an artificial pneumothorax with nitrogen on account of the presence of adhesions between the visceral and parietal layers of the pleura. He performed the operation in two stages. In the first, the patient was placed in the lateral position on the sound side, and 3 or 4 cm. of the posterior part of the upper nine ribs were removed subperiosteally through a vertical incision at the outer border of the *erector spinæ*. In the second stage, the patient was placed in the dorsal position, and a vertical incision was made $\frac{1}{4}$ inch from the lateral sternal line. About $\frac{1}{4}$ inch of the cartilage, with its perichondrium, was removed from the first seven costal cartilages. The pain resulting from the division of so large a number of ribs was very considerable and prolonged. This can be eliminated to a greater or less extent by the injection of absolute alcohol into the proximal part of the intercostal nerves during the first stage of the operation.

GYNÆCOLOGY AND OBSTETRICS

(26) Chronic Inversion of the Uterus.

J. Prescott Hedley has dealt with two cases of complete chronic inversion of the uterus by abdominal section and posterior incision of the uterus. (*The Journ. of Obstet. and Gynaec. B.E.*, January, 1915). The first patient was admitted to hospital 5 months after her fourth confinement. The placenta had been removed digitally, and there had been considerable hæmorrhage. On examination a tumour of the size of a hen's egg occupied the vagina. In the vaginal vault a thick collar of tissue formed by the lips of the cervix was found. A prolonged attempt to replace the uterus failed. The author, therefore, opened the abdomen, divided

the ring in the middle line posteriorly, cutting through the vaginal portion of the cervix, $\frac{1}{4}$ inch of the posterior vaginal wall, and $\frac{1}{4}$ inch of the posterior wall of the uterus. The reposition was then easily effected. The second patient was seen six months after the birth of her child. The placenta had been expressed, and shortly after its delivery a tumour was seen in the vagina. There was copious hæmorrhage, and the patient lost consciousness. The tumour was recognized as the inverted uterus, and was replaced. Re-inversion recurred later. An attempt continued for $1\frac{1}{4}$ hour to reduce the inversion by pressure having failed, the same operation as was performed in the first case was carried out. The patient made a good recovery. Hedley expresses the opinion that the contracted cervix can be stretched, and its resistance overcome by continuous pressure, but he is doubtful whether this procedure is less severe than treatment by incision. The use of repositors is slow, tedious, and painful. He meets the objection raised against abdominal section and incision by maintaining that accurate suture can obviate the risk of leaving a weak scar in the uterus.

R. Drummond Maxwell records two cases of the same condition (*ibid.*). He emphasizes the extraordinary rarity of inversion of the uterus. His first patient had been delivered with forceps under chloroform. No history of the third stage was available. An attempt was made to replace the uterus manually. This attempt caused great pain, and was, therefore, given up. The reposition was effected under chloroform by Aveling's repositor. Five re-applications were required before the reposition was complete. The whole proceeding occupied $43\frac{1}{2}$ hours. The patient recovered. The second case was one of the acute variety. The patient, a primipara, had been delivered with forceps, and some difficulty had been experienced in connexion with the third stage. She was seen three days after delivery. A large mass occupied the vagina, and was delivered externally. Its surface was smooth, but at the lower pole it was covered with necrotic tissue, fibrin, and placental shreds. Abdominally a peritoneal "cup" was felt. Reposition was effected in about 40 minutes. Four fingers were gradually pushed through the ring, and the fungus pushed upwards. The patient was in a very weak condition, and toxic diarrhoea set in. On the 12th day she developed symptoms of a pulmonary embolism, and on the 16th day a sudden left hemiplegia occurred, from which she died in a few hours.

(27) A Human Embryo in a Full-term Placenta.

Roy L. Moodie (*Surg. Gynec. and Obstet.*, May, 1915) describes a nine mm. human embryo which was found in the margin of a full-term placenta. The mother was aged 35, and a primipara. Her baby, weighing 9 pounds $3\frac{3}{4}$ ounces, with an abundance of hair, was apparently normal. There was nothing

unusual in the history of the woman during her pregnancy or labour. She had previously undergone the operation of appendectomy, curettage, removal of the left fallopian tube, and left ovary, and of a cyst from the right ovary. The placenta was quite normal in appearance, even on minute examination, save for the presence of a small yellowish body noticed on the extreme margin, opposite the well developed amniotic fold of Schultze. It, therefore, corresponded exactly to the site of the yolk-sac. The embryo contained in this yellow body was slightly flattened laterally. The gill arches, mandibular cleft, the limb buds, the somites, eye, heart and other features were not strongly developed. The notochord was present throughout the structure. The embryo looked as if it had obtained an age of 4 or 5 weeks, and had then been arrested in its development. Further details of the structure are given, and the author indulges in a critical analysis of the possible explanation of its occurrence. The theories dealt with include: (1) parthenogenetic development, (2) a fertilized polar body, (3) unequal twins, (4) an embryoma, and (5) superfoetation.

(28) Fibroids Associated with Pregnancy.

James Phillips (*Journ. of Obstet. and Gynec.*, B.E., January, 1915) points out that the dangers of uterine fibroids during pregnancy are: (1) miscarriage, due to the fibroid interfering with the proper expansion of the uterus, and (2) red degeneration of the tumour, with liability to infection of the degenerated growth. During labour there is danger of (1) obstruction by impaction of a fibroid in the pelvis, and (2) mechanical interference with the normal muscular contraction. He records the histories of 6 cases, and as a result of his experience comes to the following conclusions: Since many patients with fibroids have perfectly normal pregnancies, labours, and puerperia, he does not agree that hysterectomy is advisable in every case. The pregnant woman with a fibroid should be warned of the danger of her condition, and should local and general symptoms point to degeneration of the tumour, a laparotomy should be done. If the tumour seems likely to obstruct labour, it may be attacked early, or the position explained to the patient, and operation postponed until a viable child exists. The risk of a Cæsarean section plus hysterectomy is not materially greater than the risk of hysterectomy performed a month or two earlier.

(29) Rupture of the Uterus.

W. E. Fothergill records a fatal case of rupture of the uterus (*Journ. of Obstet. and Gynec.*, B.E., January, 1915). The patient was 41 years of age, and had borne 9 children. She was delivered by version on account of a transverse presentation. While removing the placenta the obstetrician felt a rent in the uterine wall on the right side. She was sent to hospital.

On admission she was collapsed and had lost a large amount of blood. The pulse-rate was 144. Shortly after the pulse became impalpable, and the patient was gasping. The abdomen was opened and a tear through the peritoneum was found extending from the anterior abdominal wall to the right of the bladder to close to the lower pole of the right kidney. The caecum and appendix were torn from their bed, and the infundibulo-pelvic ligament was involved in the hæmatoma. The uterus was removed, the peritoneum drawn together as well as possible, and a gauze drain inserted. Rigors occurred on the fourth evening and fifth morning, and death occurred on the sixth day. An isolated abscess cavity was found in the pelvis. The extensive and serious nature of the injury accounted for death. The author expresses the opinion that in about two-thirds of these cases hysterectomy saves life, if performed promptly.

(30) Ovarian Fibroids.

Alfred M. Hellman describes six cases of ovarian fibroids, and discusses the ætiology, symptoms, diagnosis, treatment, prognosis, classification and pathology of this rare condition (*Surg. Gynec. and Obstet.*, June, 1915). He finds that the ætiology is obscure. A diffuse and circumscribed form of fibroma exists, while Brokittansky has described a fibroma arising from the corpus luteum. In addition fibroids may arise from the papillæ of the ovary, and in the last place ovarian myomata are recognized. The symptoms are those of a tumour of the ovary, and the diagnosis can only be made after removal by histological examination. The prognosis after operation is good. In the majority of cases the tumours are hard and irregular, but they may be cystic. Fatty degeneration is not uncommonly met with. The histology of these growths is described in some detail.

(31) Tubercular Salpingitis with Toxic Symptoms.

Gibbin FitzGibbin (*Journ. of Obstet. and Gynec.*, B.E.) records the case of a single woman, aged 37, who complained of difficulty in reading, and failure of vision. During observation the left eye became attacked with irido-cyclitis, and numerous streaks and floating opacities appeared in the vitreous. The condition was at first regarded as syphilitic, but the Wassermann test proved negative. On careful gynecological examination a firm mass filling Douglas's pouch was discovered. A laparotomy was performed after the diagnosis of tubercular tubes had been made. The whole mass, including the uterus and appendages, was adherent to the rectum and bladder. After its removal the patient made an uninterrupted recovery, and the vision improved very considerably. The vitreous opacities cleared up almost entirely. The author attributes the eye trouble to toxins formed in the pelvis.

(Continued from page 57.)

Age: Not over 40 years, except as to 20%, up to 45 years.

Must be prepared and medically fit for any service. Every endeavour made to place each officer in a suitable position.

Pension Rights: It is understood, the same as for all Imperial officers.

Australian Forces.

Whole Time—Abroad or in Australia.

Rank: Captain. In special cases, major or lieutenant-colonel. Of the two latter not many positions available.

Pay: Captain, 22s. 6d.; major, 30s.; lieutenant-colonel, 37s. 6d. per day. Field Allowance, 3s. 6d., 5s., 7s. 6d. per day respectively, and is not paid to officers except in camp. Regulation rations free in camps.

Term: Period Abroad—For term of war. Special cases for 12 months will be recommended. In Australia—Term can be arranged.

Uniform: Necessary articles free. For service abroad, £15 extra.

Age and Physical Fitness: For duty to be performed. Compensation: For sickness, if in Australia, up to 10s. per day for six months, and other rights. If Abroad—Pay till recovered, or if permanently disabled (totally or partially) war pension rates to officer and dependants.

Whole Time in Australia for Short Periods.

Offers of duty for short periods of not less than three weeks will be accepted as required, for medical duty at camp, and in a few cases at military hospitals.

Dates for duty will, as far as possible, be arranged to meet applicants. They will be given commission in A.M.C. Reserve with rank of captain, and be entitled to all privileges.

These positions will only be available when supply of whole time officers is not sufficient.

For Duty with Transports and Returning Invalids.

From time to time services of a few medical men will be required to take medical duty on transports going to Egypt, and to return with invalids.

Rank and privileges of captain.

Term: One voyage or more.

Part Time in Australia—Daily or Weekly.

A limited number of officers is required for this duty at military hospitals.

Pay will be according to duty done. At present the members of A.M.C. Reserve are sufficient for this duty.

The following is an extract from a letter written by an Australian Lieutenant on active service to his father, and dated May 31, 1915:—

" You will see I am back at Cairo once more, but only for a short while. In about a week I shall be on my way back to the front. I will be glad too, for it is much better there than here, for now Cairo is devilish hot and slow. Since my last letter home I changed from the boat I was on, and got on a ship full of wounded coming to Egypt. The ship was under the control of Australian medical officers, who show much better attention compared with the English. The English R.A.M.C. has evidently not availed itself of the South African war, and Australia and New Zealand are miles and miles ahead in every detail. Skilled doctors, trained orderlies, and better equipment. This is not from my own experience wholly, but I am partly an English officer, owing to our brigade being attached to and supporting the British troops. All the wounded officers, who were with me, held the same opinion. Don't imagine that even the Australian medical arrangements are all they ought to be. From the time one is put on board ship at the scene of action till one arrives in Egypt the medical arrangements are rotten. There is lack of properly equipped hospital ships, and it is up to Australia to get busy and send us or send the money to equip more hospital ships. We have plenty of motors and waggons; what is wanted is ships for nurses, doctors and orderlies. By this, no doubt, the people out there have realized what war is, and instead of a lot of useless work and sending a lot of money to different funds outside Australia, all that should stop,

and we must realize that 'charity begins at home.' Once a wounded soldier is landed in Egypt he is well looked after. It could not be better; it's wonderful, but it is the getting there—and some troops never do. They are kept in big liners at a harbour near the Straits till they recover, and their lot is not to be envied. A wounded man, in order to have the wound attended to, gets his clothes cut off, but there are none to replace them; no pyjamas, clean shirts or anything of that nature, and so a great many are getting about with bandages and a blanket for clothing. I am sure if the conditions of these poor chaps were known, you people out there would soon remedy it, for, goodness knows, the poor lads deserve the best that can be done for them, and you cannot imagine what a boon it would be to them. One must have seen it to know. I am out of hospital now, and am staying at Maadi, the English suburb of Cairo, with an officer of the Sudan Intelligence Department and his wife, in a very nice house. They cannot do enough for me, and I am very comfortable. All the people here are good to the wounded, visiting them, and many, like myself, are staying with private families, which is much better than the hospital. I have my head dressed twice a day, and am lucky enough to have been able to leave the bandage off. The wound is healing up very rapidly, and I am feeling A1. I told you I think our brigade is with the British troops at the southern end of the Peninsula, and we are doing very well, and have been congratulated by all for our good work. We are the only Australians there. My battery is the right of the British line, adjoining the French line, and we are doing well. We always find time for some fun of some sort, and thoroughly enjoy ourselves."

The reference to the need for pyjamas, shirts and other clothes is worthy of careful note. Australian practitioners will read with pride the opinion expressed in regard to the Australian Army Medical Service. A third point of importance is that dealing with the necessity of providing for our own, even if this entails a decrease in assistance to our allies.

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PHARMACEUTICAL NOTES.

On the instigation of the Pharmaceutical Society of New South Wales, the Collector of Customs has revised the scale for the supply of opium and its preparations. The following annual quantities may be supplied to pharmacists and others for bona-fide medicinal purposes:—

Solid Extract of Opium	2 oz.
Liquid Extract of Opium	13 oz.
Tincture of Opium	14 lbs.
Gum Opium (including powdered Opium) ..	5 oz.

Attention is directed to the instructions that after June 30, 1915, the extracts and tinctures of opium that may be supplied by licensed importers shall be:—

Official extracts and tinctures of the B.P. 1914.

Battley's Liquor Opii Sedatives.

Ferris's *nepenthe*.

Sydenham's laudanum (*tinct. opii crocata*).

Oppenheimer's *nepentegin*.

Squire's *liquor meconicus*.

The amounts supplied are to be computed on the basis of the B.P. strength. In the case of Battley's liquor, the equivalent is to be obtained by multiplying the quantity sold by 1.7, such multiple representing the relative strength in opium of the preparation as compared with the B.P. standard.

The *Times*, of May 28, 1915, announces that the Council of the Bristol University have decided to proceed forthwith to the erection of additional buildings, using the gift made by Mr. George A. Wills, the chairman of the Imperial Tobacco Company, and his brother, Mr. H. H. Wills. The brothers gave the sum of £180,000 for the purpose of extending the Bristol University, but, inasmuch as the tender for the work required exceeded the amount available, they have increased their generous donation to £220,000.

British Medical Association News.

SCIENTIFIC.

A clinical meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on July 9, 1915, Dr. Brady in the chair.

Dr. R. H. Todd (the Honorary Secretary) apologised in the name of the President for his unavoidable absence, and also for the absence of Dr. Gordon Craig (the Vice-President), who is about to leave Australia in charge of the No. 1 Hospital Ship.

Dr. A. E. Finckh exhibited a film made from fluid drawn from the pleural cavity from a case diagnosed as tuberculosis. The patient had had pleurisy, and some years ago had been operated upon for hydatids. The present illness began a few weeks before with pain in the right side of the chest, profuse sweating, and loss of weight. There was cough and some sputum, but no blood in the sputum nor any bodies suggestive of hydatid. No tubercle bacilli had been found. The physical signs led to the diagnosis of pleurisy with effusion. The sediment of the fluid withdrawn from the pleural cavity looked under the microscope like a blood specimen from a case of myeloid leucæmia. There was a large percentage of eosinophile cells, including polymorphonuclears, megaloblasts, normoblasts, etc. The condition has been described as *pleural eosinophilia*. The blood picture was normal. Dr. Finckh had never come across a specimen like the one exhibited before, and the reason why he brought it to the attention of the members was that he hoped that some suggestion as to the diagnosis might be made. That afternoon the pleural cavity had been punctured again, and a hydatid cyst had been discovered in the lung. He did not suggest that either tuberculosis or hydatid could cause this eosinophilia, but he could not explain how these various cells got into the fluid.

Dr. D. Kelly read a paper on *operations on the tonsils*. He stated that he did not intend to indicate the necessity for operation, but would restrict himself to the description of three operations, one of which would be found quite adequate in all diseased conditions of the tonsil, save malignancy, if performed with due regard to the condition. The first was removal by the guillotine (Mackenzie's or some other instrument). He described in some detail the best method of using the guillotine. A good light was not essential, as the operation was conducted by touch. The head should be pulled over the end of the table. Light anaesthesia was required. The second operation was known as sluderizing the tonsils. The instrument used might be the ordinary Mackenzie guillotine or one of the special instruments, such as O'Maly's. In this operation a good light was essential. Deeper anaesthesia was required. The ring of the guillotine pushed the tonsil upwards and forwards toward the supra-tonsillar fossa. At the same time the index finger of the left hand forced the tonsil downward and forward into the ring. The tonsil could be felt almost to jump through the ring. The blade was then pushed home, and a complete enucleation was effected. Guillotining took about 10 seconds, and sluderizing about 20. In order to overcome the danger of severe hæmorrhage, Joseph Beck had devised an instrument consisting of a ring with a hidden snare. The tonsil is snared away, instead of being cut. Dr. Kelly stated that either of these operations would fail, if there had been previous peritonsillar abscess, with subsequent adhesions, if there had been an attempt at previous dissection, or if the tonsils were flat and extended well down into the pharynx. In these cases enucleation by dissection should be performed. This was a difficult operation. A good light was absolutely necessary. Anaesthesia was induced in the ordinary way, and continued with a Junker's inhaler. The head was brought well over the end of the table. An injection of sterile water or saline fluid through the anterior pillar caused the tonsil to stand out well. It was then seized with a pair of forceps, and traction applied. Blunt, slightly curved scissors were used for the dissection, which was started at the supra-tonsillar fossa through the anterior pillar. Bleeding vessels should be clamped with fine silver wire, applied with a Cushing forceps or ligated. The risk of hæmorrhage was diminished by the proper treatment of cut blood vessels. The liability of adhesions forming between the an-

terior and posterior pillars could be prevented by careful dissection. The operation took from 10 to 30 minutes. In conclusion, he mentioned that severe and continued hæmorrhage could be arrested as a rule by styptics, adrenalin, or pressure. At times, a swab sewn in between the pillars was necessary. As a last resort, the external carotid could be tied.

In the discussion, Dr. Charles F. Warren regarded the removal of tonsils as an important surgical procedure. The cause of its frequent failure was that it was so often regarded as a trivial operation. He pointed out that Sluders and O'Maly performed the former's operation in a somewhat different manner to that described by Dr. Kelly. No operation could be more quickly performed than Sluders' operation in O'Maly's hands. Dr. Warren described Tilley's method of removing tonsils with a cold snare. The dissection was carried out in the usual way. The snare was slipped under the anterior pillar, and a small artery lying immediately behind the last named structure was tied. The operation could be performed without causing the patient to lose more than 10 drops of blood. He maintained that the danger of the operation was the danger of the anaesthesia. He quoted a number of cases in support of this contention. In a case recently recorded in the *Journal of Laryngology*, the patient had died suddenly during the second hour of the operation! He laid great stress on the skill of the anaesthetist. In regard to hæmorrhage, he called attention to an instrument devised by Elphink, called the hæmostatic guillotine. Theoretically, the patients could not bleed when this instrument was used, but in practice they did. He warned those present against the use of morphine before the operation.

Dr. Worrall asked Dr. Kelly if he removed adenoids at the same time as the tonsils. Later on in the discussion, he interposed the question, "Has the tonsil any useful functions at all, or should it be removed in every case?"

Dr. Shelden spoke from the point of view of the anaesthetist. He has administered anaesthetics many hundred times for the removal of tonsils, and uttered a strong protest against the use of the Junker inhaler. He thought that anaesthetists should have a little courage to resist doing exactly what the surgeon wanted. The surgeon should be put to a little inconvenience at times, for the safety of the patient. He advocated a light anaesthesia; after the removal of the first tonsil, the patient should be allowed to come to a little, and before the surgeon began on the other, the anaesthesia could be renewed. In regard to the question of bleeding, he suggested that when enucleation was being performed on both tonsils, it was advisable to loosen the tonsil and leave it in its bed until the second tonsil had been freed. Both tonsils could then be removed at the same time, and in this way bleeding during the anaesthesia would be obviated. He preferred the patient to be lying on one side than with the head hanging over the end of the table.

Dr. Lipscomb asked whether there was any objection to the removal of the tonsil by Mackenzie's guillotine, and if there should be any shreds which gave trouble later on, to nibble them away with the cautery.

Dr. Dunn spoke of the practice followed at the Central London Hospital, where Sluders' operation was performed with Mackenzie's guillotine, under ethyl-chloride anaesthesia.

Dr. Binney raised the pertinent question of the pathological conditions which justified one of the three operations named. He emphasized the necessity of choosing an operation which the condition of the tonsils demanded.

Dr. Stacy agreed with some of the previous speakers that the hanging position of the head during the operation was satisfactory, but pointed out that a sitting-up position was advisable after the operation was over. He cited a case in which death from hæmorrhage took place, because the patient was in the recumbent position and the bleeding was not discovered. If the patient had been sitting up, the hæmorrhage would have been recognized and dealt with.

Dr. Brady spoke of the time when he used chloroform, and of its disadvantages. He used the open ether method now. Turning to technique, he said that O'Maly called his instrument a tonsillotome. It was certainly nothing of the kind, and was not devised to cut at all. The tonsil was shelled out, somewhat like the skinning of a rabbit. If a cutting instrument were used, hæmorrhage would be more

likely to occur. It was very dangerous to use the cautery. The cold snare was useful at times, but he warned surgeons most strongly against the use of the cautery snare. Furthermore, he was afraid of scissors. In dissecting out the tonsil, he always used a knife, and he claimed that he could see where its point was and what he was doing. This was not the case with scissors. It was possible to remove even deeply submerged tonsils by O'Maly's instrument without any loss of blood. He considered Dr. Binney's question a very important one. Large hypertrophied tonsils caused mechanical obstruction, and should be taken off. When there were septic pockets in the tonsils, the organ was a serious annoyance to the patient and a source of danger. These tonsils should be enucleated. He removed the tonsils from people who had recurrent attacks of peritonsillitis. The function of the tonsil was connected with blood formation, but if they were removed, there was plenty of adenoid tissue in other parts to carry on this function, including a pair of lingual tonsils. He preferred the hanging head position for operation. This gave a good view, and a good view was, in his opinion, essential.

Turning to the question of the arrest of hæmorrhage, he wished to add to the means enumerated by Dr. Kelly the application of pressure forceps. This should always be done when a bleeding vessel could be seen and even when this was not the case, it was useful to pick up the piece of tissue from which the blood was issuing. Another method of dealing with bleeding was to apply the peroxide of hydrogen, either alone or with tannic or gallic acid. He recited the details of an interesting case in which the patient had had a severe hæmorrhage coming on some hours after the removal of the tonsils. In this case, he felt sure that no hæmorrhage would have taken place, had the patient obeyed his orders to lie down for the rest of the day.

In his reply, Dr. Kelly explained to Dr. Binney that he had said at the beginning of his paper that it would make his communication too long if he discussed the causes for which tonsils were removed. He objected to the method of allowing the patient to come out of the anaesthesia between the removal of the first and that of the second tonsil. To Dr. Warren he urged that he had not attempted to describe O'Maly's operation, but had described the modification of Sluders' operation as he practised it. He did not think that Sluders' directions of looking for the *eminencia alveolaris* were followed by many surgeons. His objection to the side position was that broncho-pneumonia might arise from blood sucked in during the operation. To Dr. Brady he stated that he never used the cautery snare himself. He removed adenoids at the same time as the tonsil in suitable cases. In this connexion he described a device of Beck's by means of which a good view of the post nasal fossa could be obtained. A catheter was passed through one nostril into the pharynx and thence back through the other nostril. The ends were then pulled forward and a better view was thus obtained. He expressed the opinion that it was impossible to remove a tonsil which had been the seat of persistent abscess or one that could not be protruded through the ring by sluderization. In regard to scissors, he used blunt pointed, slightly curved scissors, and claimed that with practice the points could be seen well.

Dr. E. H. Binney demonstrated a new device for the treatment of talipes equino-varus. It consisted in using strips of zinc oxide plaster to secure a stirrup bandage, acting from the outer aspect of the thigh to the outer edge of the foot. The stirrup could be shortened by turning a rod of wood in the manner of a Spanish windlass. It was the latter device which Dr. Binney believed to be new, whereas the use of zinc plaster was well known.

Dr. Lipscomb read the notes of three cases of *gall bladder surgery*. All three cases had been dealt with during the previous month. The first case was that of a man, aged 36 years, who had been healthy and temperate. The illness began suddenly with pain and tenderness over the gall bladder. The temperature was 102°, and vomiting occurred. After the first acute symptoms had passed off, a distinct diaphragmatic rub was noted on the left side, and lasted for two days. Operation was delayed, but within the following 24 hours the patient had a very profuse sweating, followed by pain on the right side, low down in the axillary line. A diaphragmatic rub developed on the right side,

No rigors occurred, but the fever was of a septic type, and some jaundice appeared. An operation was performed, and the gall bladder exposed by means of an incision through the right rectus. There were no adhesions, but the gall bladder was found to be distended with semi-purulent fluid. There were no stones, and the ducts were free. The liver was enlarged, swollen and softened, and its surface lustreless. The drainage from the gall bladder was not free, and all the signs and symptoms of septic poisoning led to the patient's death eight days after the operation.

The second patient was a woman, aged 35. She had had a sudden attack of pain in the gall bladder region a week before she was seen by Dr. Lipscomb. This was seven weeks after her fourth parturition. The gall bladder was palpable and tender, and there was some fever. After the pain had subsided somewhat, it was found that it was shifting toward the ileo-caecal region. The gall bladder could be mapped out. It was pear-shaped, and extended to the level of the anterior superior spine of the ilium. The operation was performed without loss of time. The gall bladder was found to be quite free of adhesions, and of great size. It extended below the level of the umbilicus. The appendix was not affected. About four ounces of semi-purulent fluid, containing fibrin flakes, were drawn off. The wall of the gall bladder was so much hypertrophied that dividing it was like cutting through the cervix in the operation of hysterectomy. Eight medium-sized stones and a number of smaller ones were found. One stone was impacted in the cystic duct, blocking the outlet. This stone had to be broken up before it could be removed. The mucous membrane was swollen and engorged, and had a mulberry-like appearance. In inserting the drainage tube, it was found to be quite impossible to use a second Lembert suture and to tuck in the cut edges as usual. A cigarette drain was used. The patient made a good recovery, the drainage was satisfactory and on the 20th day after operation she was up and about.

The third case was that of a very fat woman, aged 48 years. She had been healthy up to the onset of her present illness. Four weeks previously she had had a febrile attack, with persistent headache and pain and tenderness over the right uterine appendages. The Widal test proved negative, and Dr. Lipscomb made the diagnosis of acute salpingitis. The attack passed off, but vomiting set in later, and she had a typical attack of biliary colic. The pain was relieved by $\frac{1}{2}$ grain of heroin, given hypodermically. A similar attack occurred on the following night, and was only partly relieved by $\frac{1}{4}$ grain of morphine. Slight jaundice developed, and bile appeared in the urine, but the stools still contained bile. The operation proved extremely difficult, in spite of a preliminary injection of morphine and atropine, full anaesthesia, a large incision and a perfect adjustable gall bladder bar. The liver was not increased in size, but was tucked under the lower ribs. The gall bladder was free of adhesions, and was not large. It was very tense, and its wall was hypertrophied. He failed to pick it up with ordinary forceps, and was forced to use tooth forceps. A number of stones was found and some débris. There was also some semi-purulent fluid. The ducts were free. The gall bladder was cleaned and a tube stitched in. A second suture could not be inserted. A cigarette drain was used. The drainage was satisfactory at first, but after six days the tube became blocked, and retention of pus followed. Some infection of the wound was noted. After removal of the drain she improved considerably. He considers that the stone-carrying bladder probably became infected at the time of her previous attack. Dr. Lipscomb regrets that he did not stitch the cut edges of the bladder to the anterior aponeurosis, in order that better and longer drainage might have been ensured.

Dr. Lipscomb expressed the opinion that cholecystostomy was undoubtedly the proper operation in the first and third cases, and probably in the second, although cholecystectomy would not have been wrong. It would always be possible to perform a cholecystectomy at a later date, if the subsequent history demonstrated the wisdom of this course.

The discussion was interesting and bright. Dr. Binney opened it with a question whether in the first case of suppurative cholangitis Dr. Lipscomb was absolutely certain that there was no stone in the biliary tract. Dr. Kelly referred to the second case, in which he would have re-

moved the gall bladder. It seemed to him that this was a suitable case for removal, as it was practically a useless gall bladder.

Dr. Worrall asked Dr. Lipscomb whether he stitched the gall bladder to the anterior aponeurosis. The second case illustrated in a most striking manner the effect of pregnancy. Pregnancy favoured stasis, and stasis favoured infection in every part of the body. The patient had become infected as a result of the stasis induced by her recent pregnancy. Dr. Worrall was extremely emphatic in denouncing the cigarette drain, as well as the employment of gauze for the purpose of draining. The cigarette drain acted by capillary action for a few minutes, and then failed. In a short time, the gauze became quite blocked, and it then acted as a cork. He never used any other drain than a rubber tube. Gauze might be used to preserve a passage or to close off the peritoneum from infection, but never for the purpose of drainage.

After Dr. Sheldon had raised the point of the diagnosis of the second case, Dr. Stacy expressed the opinion that while gauze should not be used as a drain, the cigarette arrangement was quite useful. Without a casing of rubber tissue the gauze certainly acted like a cork, but with it, it served its purpose well for a time. In regard to the first case, he stated that the fact that trouble existed outside the gall bladder at the time of the operation indicated a very serious condition. The patients nearly always died. The only chance lay in early drainage of the gall bladder. In the second case, he was of opinion that Dr. Lipscomb removed the tube too early. The great hypertrophy indicated an obstruction in the cystic duct, and, in these cases, long drainage was necessary. He pointed out that the tendency of the day was to perform cholecystostomy rather than cholecystectomy, which formerly was preferred. In conclusion, he urged that the history should be studied very carefully in every case. The differential diagnosis between typhoid infection and gall stones was at times very difficult.

Dr. Flynn asked Dr. Lipscomb whether he had noticed any symptoms which might have led him to believe that the second patient had had gall stones. Moynihan had expressed the opinion that there was always a history of inaugural symptoms, which were frequently put down to indigestion. These were usually flatulence and a feeling of fullness after food. The inaugural symptoms were traceable to the fact that altered bile did not neutralize the chyme as it should, and a message was sent up to the pylorus not to allow any more chyme to pass down at the usual rate. Enlarging on the symptoms ascribed to indigestion, Dr. Flynn pointed out that an organic cause was frequently found in the appendix and in the gall bladder. The gall bladder was not a reservoir for bile; it was not large enough. It served the purpose of controlling and regulating the flow into the duodenum. Bile, as an excretion, was produced continuously, but as a secretion, was only required intermittently. He called attention to the fact that bile activated the pancreatic juice, and that without this addition, the latter was unable to exercise its full chemical action. The duodenal secretion regulated, under normal conditions, the flow of the gall-bladder. Turning to the choice between cholecystostomy and cholecystectomy, he found a ready answer. The cystic duct was kept patent by the spiral valve of Heister. If the channels were patent and the gall bladder was capable of functioning as a regulator through which the bile could pass on in proper quantities, drainage should be employed, while only when it was so far disintegrated that it could no longer carry out its physiological functions should the gall bladder be removed. In the second case, the removal of the gall bladder would have deprived the patient of an excellent source of drainage. He also made some remarks on the effect of giving small quantities of food at short intervals, for the purpose of relaxing the sphincter at the ampulla of Vater, and by lowering the pressure, diminishing the reflux of bile. He congratulated Dr. Lipscomb on his excellent paper.

Dr. Abbott agreed with Dr. Worrall in regard to drainage. The only use of gauze which found favour with him was to wall off the peritoneum. He gave some details of a case in which he had used gauze for this purpose in the presence of extensive malignant disease of the gall bladder. Referring to the choice between incision and drainage, and removal, he said that he always attempted to save the

gall bladder if this were possible. Occasionally he found it advisable to perform a cholecystectomy later on, after cholecystostomy had been done in the first place.

Dr. Brady called attention to the fact that at the last meeting of the Branch, Dr. Thring had dealt with this highly interesting question of gall bladder surgery, and that there had been a good discussion then.

In his reply, Dr. Lipscomb made passing reference to the variety of difficulties which were met with in gall bladder operations. In reply to Dr. Binney, he recited the means he had adopted to ascertain whether there were any stones in the bile ducts. None had been discovered. In regard to the first case, the fact that the rub was first on the left side and later on the right was puzzling. When the sweating occurred, he thought of liver sepsis, and he was convinced that the cholangitis had been preceded by a perihepatitis. The man had been previously healthy. Turning to Dr. Worrall's question, Dr. Lipscomb said that, as a rule, he did not unite the gall bladder to the aponeurosis, but trusted to the drainage tube. He regretted that he had not done this in the third case, as it would have ensured longer drainage. He explained that he used the cigarette drain partly to stop bleeding, in the cases in which he could not turn the edges. The blood tended in these cases to block the drain, and, in his experience, a cigarette drain obviated this. He agreed with Dr. Stacy that the pendulum had swung back in favour of cholecystostomy. It was certainly safe in the second case, while, even had he wished to remove the gall bladder in the third patient, the fat abdomen and the other difficulties would have rendered this operation almost impossible.

MEDICO-POLITICAL.

A special meeting of the Council of the Victorian Branch was held in the Medical Society Hall on June 18, 1915.

Colonel Cuscaden, P.M.O. of the 3rd Military District, explained the requirements of the military authorities in regard to the services of medical men, both at home and abroad. Professor Berry pointed out that it was essential that the whole medical profession should be organized, in order that it might be ascertained which men were available for military and civil service. He advised a census and card catalogue. Colonel Cuscaden said that he welcomed any help that the Branch could give him.

A second special meeting of the Council of the Victorian Branch was held on June 23, 1915, Dr. Honman (the President) in the chair.

Professor Berry was elected a member of the Council. A circular letter and leaflet framed by a sub-committee with a view to the establishment of a record of members for military purposes were read and adopted. The scheme was sent to the conference of the Federal Committee and the Principal Medical Officers of the six Military Districts for consideration. Dr. W. R. Boyd was appointed representative of the Branch on the Federal Committee, in place of Dr. Ramsay Webb, who was absent from the State on military service. Professor Berry was appointed to the War Organization Sub-Committee.

A meeting of the Council of the Victorian Branch was held on June 30, 1915, Dr. Honman (the President) in the chair.

The resignation of the Honorary Assistant Treasurer (Dr. Carl Dyring) was accepted with regret. Dr. Dyring had been accepted for military service abroad. The Hon. Librarian (Dr. Noyes), who had left in charge of a troopship, was given leave of absence during his term of war service.

A letter was sent by the Council to Mr. G. A. Syme, conveying its deep regrets on learning that he was suffering from a septic infection of his right hand and arm. Mr. Syme had informed the Council that he would be unable to act as representative of the Branch on the Council of the British Medical Association in London during the year 1914-1915.

The Council was informed that the Ancient Order of Foresters was demanding certificates of good health for re-insurance from their court surgeons without granting extra payment. This certificate was not provided for in Section 73 of the General Laws of the A.O.F., nor in Schedule E. (the medical agreement schedule). The Council authorized

a circular to be sent out to members concerned, warning them not to give these certificates without fee, pending negotiations.

The attention of members was drawn to the fact that certain advertisements still appearing in country newspapers were contrary to the rules recently issued by the Branch.

A letter was received from Dr. H. Pern, of Yarram, setting forth that the affairs of the Yarram Hospital had assumed a new aspect, and that the scheme for an intermediate hospital had been finally abandoned. The Yarram Hospital would be conducted exclusively as a public hospital.

It was decided to collect photographs of all past Presidents of the Victorian Medical Society and of Victorian Branch of the British Medical Association, both before and since the amalgamation of the two bodies. The photographs will be kept in a suitable album, and may prove of considerable value and interest in the course of years.

A letter was received from the Hon. Secretary of the Wimmera Division, to the effect that a resolution had been passed on May 26, 1915:—

That this Division adopts the principle that if a medical practitioner leaves his town or district for active service, the others shall conserve his interests to their utmost during his absence, and shall hand back his patients and appointments on his return, or to his successor if the practice be sold.

A vote was taken by referendum on the following matter: Are you in favour of the adoption by the Association of the following resolution, viz:—

Any member of the Association, either on commencing practice in a district, or subsequently, who may desire appointment as medical officer to a Friendly Society or a Miner's Lodge, or any similar position, may apply for such appointment in the following terms:

To the Friendly Society.—Having commenced practice (or being in practice) as a medical man at _____, I desire appointment as one of the medical men available to your members.

(Signed) A.B.

Such application shall be unaccompanied by any testimonial or recommendation.

The number of affirmative replies was 126, and of negative replies was 32.

The Ethical Committee recommended that, owing to the smallness of the voting and the evident lack of interest, it was inadvisable that any further action be taken at present. This recommendation was adopted by the Council.

Dr. Boyd and Dr. Latham reported the proceedings of the conference of the Federal Committee and the Principal Medical Officers of the Military Divisions, as well as the meeting of the Federal Committee. The circular dealing with the organization of the medical profession for military purposes, as amended by the Federal Committee, was approved, and will forthwith be sent out to members. This circular appeared in the issue of *The Medical Journal of Australia* of July 3, 1915.

The replies to this circular, when received, will be card-indexed, and a sub-committee, consisting of Professor Berry, Dr. Latham and the Secretary, was appointed to take charge of this matter.

The Honorary Treasurer presented the half-yearly statement. There was a credit balance to the Branch of £656 17s. 6d. After payment to the Medical Society and to *The British Medical Journal*, together with sundry accounts, there would be a balance of £377 1s. 2d. A small sub-committee was appointed to see what economies could be effected in consequence of increased expenditure, due to the war and of smaller revenue due to the number of members who have left for the front.

The financial statement of the Medical Society of Victoria showed a credit balance of £360 1s. 1d. After receipts from the Branch and payment to the Australasian Medical Publishing Co. for *Journals*, together with payment of salaries, etc., there would be a credit balance in hand of £473 19s. 5d.

BELGIAN DOCTORS' RELIEF FUND.

New South Wales.

The following subscriptions have been received during the fortnight ending July 13, 1915:—

	£	s.	d.
Amount previously acknowledged	614	10	6
Dr. Adams, F. C., Dubbo	1	1	0
„ Binns, W. J., Kogarah	3	2	0
„ Denniston, W. C., Hunter's Hill	1	1	0
„ Humphrey, E. M., Hornsby	1	1	0
„ Page, Earle, Grafton	3	2	0
„ Shellshear, W. G., Wallsend	1	1	0
„ Watt, G., Sydney	3	2	0
„ West, W. F. W., Camden	1	1	0
Total	£630	5	6

TOBACCO FUND.

A subscriber to the Overseas Club Tobacco Fund has made the suggestion that small subscriptions should be handed to our representative in each State, in order to obviate the loss on the exchange and the trouble entailed in sending a few shillings. Members are invited to hand to the local representative of the *Journal* in each State any contributions which they may be good enough to wish to invest in tobacco for "Tommy." Dr. Yule or Dr. Latham will be asked to receive these contributions in Melbourne, Dr. Hone in Adelaide, Dr. Brockway in Brisbane, Dr. Hadley in Perth, and Dr. Sprent in Hobart. The following additional subscriptions have been received: Amount previously acknowledged, £25 6s.; Dr. R. H. Elsworth, Vic., 10s. 6d.; Dr. T. E. Green, Bendigo, 5s.; Dr. Margaret Harper, Sydney, 5s.; Dr. Henry Howard, Melb., 10s.; Dr. J. MacMaster, Sydney, 10s.; Dr. A. J. Ople, N.S.W., 5s.; Mrs. M. W. Ratz, Vic., 2s.; Mrs. W. H. Tricks, Vic., 2s.; Total, £27 15s. 6d.

Public Health.

SMALL-POX IN AUSTRALIA.

The following bulletin has been issued by the Federal Quarantine Bureau on July 2, 1915:—

New South Wales.

The number of cases of small-pox reported in New South Wales from June 25 to July 1, 1915, was 6, all of which occurred in the Newcastle district.

The daily incidence of cases was as follows:—

	Cases.
June 25	Nil.
June 26	Nil.
June 27	Nil.
June 28	Nil.
June 29	4
June 30	2
July 1	Nil.

The following are the towns from which the cases were reported:—

	Cases.
Kurri Kurri	4
Cessnock	1
Standford-Merthyr	1

The last case in the metropolitan district of Sydney was reported on March 25, 1915.

Other States.

The other States of the Commonwealth continue to be free from the disease.

SMALL-POX IN NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending July 10, 1915:—

Country—	Cases.
Cessnock	1
Hamilton	1
Kurri Kurri	1
Total	3

THE HEALTH OF VICTORIA.

The following notifications have been received by the

Department of Public Health, Victoria, during the week ending July 7, 1915:—

	Metro-politan.		Rest of State.		Totals.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Diphtheria	54	3	45	1	99	4
Scarlatina	8	0	3	0	11	0
Enteric Fever	1	0	3	2	4	2
Pulmonary Tuberculosis	16	9	7	1	23	10

During the half-year ending June 30, 1915, the number of cases of diphtheria, scarlatina, enteric fever, and pulmonary tuberculosis notified is as follows. For the purpose of comparison, the corresponding figures for the years 1912, 1913 and 1914 are also given.

Half-year ending	1912.		1913.		1914.		1915.	
	Whole State.	Metrop. Area.	Whole State.	Metrop. Area.	Whole State.	Metrop. Area.	Whole State.	Metrop. Area.
Diphtheria	2988	1447	2879	1209	2283	1045	2451	1188
Scarlatina	353	130	149	81	140	111	365	183
Enteric Fever	955	217	952	220	940	251	807	152
Pul. Tuberculosis	652	392	679	383	642	385	757	491

The following notifications have been received by the District Health Officer for Auckland during the month of June, 1915:—

	City Cases.	Suburbs Cases.	Country Districts Cases.	Total Cases.
Scarlatina	16	7	7	30
Diphtheria	11	11	22	44
Enteric Fever	0	8	31	39
Tuberculosis	6	7	13	26
Blood Poisoning	1	3	1	5
Varicella	18	12	15	45

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending July 3, 1915:—

Disease.	No. of Cases notified.
Diphtheria	38
Varicella	15
Pulmonary Tuberculosis	10
Puerperal Fever	6
Scarlatina	4
Enteric Fever	5
Cerebro-Spinal Meningitis	3
Erysipelas	1
Anterior Poliomyelitis	1
Total	83

THE HEALTH OF HOBART.

Dr. Gregory Sprott, Medical Officer of Health for the City of Hobart, has issued his annual report for the year ending December 31, 1914.

The population of the city was estimated at 31,955. This number is the same as that of the previous year. One thousand two hundred and twenty-two births were registered during the year, which is equivalent to a birth-rate of 38.45 per 1,000 of population. This rate has only been exceeded once during the last 10 years, namely, in 1912, when it was 38.62. The lowest rate recorded since 1904 was in 1908, when it was 25.4. During the year 1914, 127 infants under one year of age died. The infantile mortality was thus 103.92 per 1,000 births. In 1909 the infantile mortality was 78.42, and in 1904 it was 141.15. Of the 127 deaths 43 were due to gastritis and gastro-enteritis, 28 to premature birth, and 19 to malformations, marasmus and inanition.

While 1,222 infants were born only 416 persons died. The death-rate was equivalent to 13.01 per 1,000 of population. The death-rates for 1905 to 1914 were: 14.32, 14.64, 14.32, 12.39, 9.9, 10.96, 13.37, 14.65, 15.55, and 13.01. Diseases of the heart caused 36 deaths, pneumonia 30, cancer 29, enteritis 21, tuberculosis 17, gastro-enteritis 15, Bright's disease 15, etc.

The number of cases of infective diseases notified during the year was 282. This number is considerably higher than that of 1913 (201), and 1912 (101). There were 22 cases of

enteric fever reported, and 2 deaths. Dr. Sprott attributes the low incidence to the sewerage of Hobart. The incidence of diphtheria was greater. There were 186 cases, of which 151 were treated at the hospital at Vaucluse, and 35 at the patients' homes. The death-rate among the hospital cases was 2.6%, and of the home-nursed cases 2.85%. Dr. Sprott urges that the fauces of all the children in a school in which a case of diphtheria has occurred should be examined bacteriologically.

Thirty-two cases of scarlatina were notified during the year, and 35 of varicella. There were 3 cases of puerperal fever, with 1 death, and 2 of *ophthalmia neonatorum*. The death-rate of tuberculosis was 4.08%. There were 63 cases of pulmonary and laryngeal tuberculosis notified during the year. Dr. Sprott repeats his demand for a home for tuberculous patients in an advanced stage of the disease.

Legal proceedings for neglect to notify notifiable diseases were taken in one instance. The number of premises disinfectated after the removal or recovery of persons suffering from notifiable diseases was 347.

The Infectious Diseases Hospital at Vaucluse has served a good purpose during the year, but the new hospital still remains empty. The number of patients admitted into Vaucluse was 224, of whom 8 died.

In regard to cow sheds and dairies, 92 applications for licenses were considered, and the licenses granted. Of 41 samples of milk analysed, two proved to be adulterated. In one case the vendor was cautioned, and in the other he was fined £5 and costs. During the year approximately four tons of food stuffs were seized owing to being unfit for human consumption. At the city meat depot about 1 ton 3 cwt. of lamb, mutton, beef and pork were condemned and destroyed.

The chapters dealing with hotels and public-houses, factory inspection, graveyards, and open spaces do not contain any data of considerable importance. It is stated that 5,520 rats were destroyed. A capitation fee of twopence was made for each rat, and 1,007 tins of rat poison were distributed free. In regard to house inspection it was found necessary to condemn 9 houses, and to demolish 18. Dr. Sprott urges the erection of a garbage destructor, which is under consideration.

The concluding paragraph contains a short account of the work of the staff of the Medical Officer of Health.

THE SPREAD OF VENEREAL DISEASE.

At the invitation of the Council for Civic and Moral Advancement, the Council of the New South Wales Branch of the British Medical Association appointed Dr. George Armstrong (President), Dr. W. H. Crago (Hon. Treasurer) and Dr. R. H. Todd (Hon. Secretary) to attend a conference on the question of the spread of venereal disease. The President was unfortunately unable to attend on July 8, 1915. The following members of the Council for Civic and Moral Advancement were present: The Rev. Principal Thatcher (Camden College) in the chair, Rabbi Cohen, Rev. Dr. Carruthers, Rev. Professor Macintyre, Rev. Wentworth Shields (representing the Archbishop of Sydney), Rev. A. Yarnold, Rev. C. J. Prescott (Newington College), Rev. A. Stephen, Mr. W. Winn, the Hon. Thomas Brown, M.L.A., Mr. M. Gotthelf, and the Rev. C. E. James (Secretary).

The Council for Civic and Moral Advancement has had under review the grave question of the spread of venereal disease. Application has been made to the Council by persons who are interested in this matter, that they should endeavour to discover some method by which the public conscience might be aroused, and the public mind impressed with a sense of the seriousness of the subject. In order to arrive at a practical conclusion, it was thought that the opinions held by members of the medical profession should be ascertained.

The conference was of an informal nature. Dr. Todd dealt with the following question, explaining the views which have been expressed by the Council of the Branch on other occasions, and where no such opinions have been arrived at, giving his own views: (1) Is segregation of prostitutes advisable (the C.D. system)? (2) Are night clinics likely to be of practical value? (3) Can any methods of public propaganda of an educational nature be suggested with a reasonable prospect of effecting a diminution of infection, without carrying with it obvious moral objec-

tions? (4) What is the probable value of compulsory notification of venereal disease? (5) Is venereal disease spread as widely by amateur prostitutes as by professional ones?

A short, general discussion followed, but no resolutions were arrived at.

Vital Statistics.

VITAL STATISTICS OF SYDNEY AND NEWCASTLE.

The Government Statistician of New South Wales has prepared reports dealing with the vital statistics of the Metropolitan and Newcastle districts for the month of May, 1915.

In the metropolitan area there were 1,748 births, 923 of males and 825 of females. The rate, which is equivalent to an annual birth-rate of 27.89 per 1,000 of population, was not satisfactory, being 5% below the average for May of the previous five years. The illegitimate births numbered 137, being slightly below the average of the last five years. There were 315 births, or 18% of the total births, in hospitals and other institutions.

During the month, 652 persons died. Of the total number of deaths, 367 were of males and 285 of females. This mensural mortality corresponds to an annual death-rate of 10.4 per 1,000 of population, which is satisfactory, being 2% below the average of the previous five years. The infantile death-rate was 52 per 1,000 births. This rate is low, being 19% below the average of the last five years, and denotes extremely healthy conditions. Of the total deaths, two hundred and sixty-one, or 40% of the whole, occurred in hospitals and other institutions. Among the very old persons who died, two were aged 90, one 91, two 92, one 94, and one 97 years.

Diseases of the heart contributed most largely to the death-roll, with 77 deaths. Cancer killed 59, and pulmonary diseases 51 persons. Acute and chronic Bright's disease caused 49 deaths. Hæmorrhage of the brain and developmental diseases in children accounted for 40 deaths in each group. There were 39 demises from senility, and 34 from pulmonary tuberculosis. Diarrhœa and enteritis caused 33 deaths. There were 22 fatal accidents, and 19 deaths due to infectious diseases. Analysing these figures further, it may be noted that the returns of the Board of Health showed that 63 cases of typhoid fever, 240 of diphtheria, 386 of scarlatina, 12 of malaria and one of infantile paralysis were notified during the month. Diphtheria caused six deaths, all in children under five years of age. The fatal cases were distributed widely over the suburban area. There were three deaths each from typhoid fever and influenza. Two deaths occurred from scarlet fever, both in persons dwelling in the Illawarra suburbs. Two deaths from measles and one from whooping-cough occurred in children under five years of age. Of the 208 deaths in persons over 65 years of age, 38 were entered as due to senility, 33 to cardiac troubles, 11 to other vascular diseases, 22 to cerebral hæmorrhage, 21 to cancer and 18 to nephritis. The three deaths from influenza occurred in individuals over 65 years old. Only six of the 36 deaths certified as due to pneumonia occurred in this age-group. Of the deaths among infants, not due to pre-natal causes, 21 out of 51 were caused by enteritis. As the mean temperature for the month was 58° F., this is a high mortality, which should necessitate still greater care in the feeding of infants. Only nine deaths were certified as due to puerperal conditions. This low rate suggests that some deaths after child-birth are not recorded as such in these tables.

In the Newcastle district, there were 161 births, 71 of males and 90 of females. Three of these children were illegitimate. The mensural birth-rate is equivalent to an annual birth-rate of 33 per 1,000 of population, which is somewhat higher than the average of the last five years. The deaths numbered 55, equal to an annual death-rate of 11.28 per 1,000 of population. There were 28 deaths of males and 27 of females. Thirteen deaths occurred in public institutions. The death-rate is slightly higher than the average of the five previous years. The deaths of infants represented 99 per 1,000 births. About 31% of the total number of deaths were in persons under five years of age, and of these one-half were under one year old.

Diseases of the circulatory system accounted for eight deaths. Developmental diseases of infants caused 12 deaths. Cancer and phthisis each killed two persons. There were no deaths from epidemic diseases. The number of fatal accidents was four, a number very close to the average for the last ten years. The proportion of deaths due to fatal accidents in the Newcastle districts is much greater than in the metropolitan area. Roughly, one death in 30 deaths in the Sydney district is due to an accidental cause, while one death in 15 deaths in the Newcastle area is produced by accident.

Medical Matters in Parliament.

NEW SOUTH WALES.

On July 8, 1915, Mr. Griffith moved "That this House will, on its next sitting day, resolve itself into a committee of the whole to consider the expediency of bringing in a bill to amend the 'Medical Practitioners Act, 1912.'"

On July 7, 1915, Colonel Onslow, member for Bondi, asked the Colonial Secretary:—

(1) Is it a fact, as stated recently in the public Press, that he proposes to commit the country to a large expenditure for the purpose of ensuring "painless labour" by means of a new drug which he names as "detoxinated morphia"?

(2) If so, was his proposal made after consultation with his Chief Medical Officer?

(3) Has his proposal any other foundation than that to be found in *Nash's Magazine*, a popular American publication?

(4) Is it a fact that the French War Office inquired of the French Academy of Medicine whether it could recommend the use of the drug in question in the military hospitals, and received in reply a unanimous and emphatic negative?

(5) Is it a fact that the *American Journal of Obstetrics*, in its current issue, contains an article which refers to the pretensions of treatment by this drug in terms of scathing ridicule and contempt?

The Colonial Secretary replied in the following terms:—

(1) No.

(2) The Director-General of Public Health is making inquiries at the cost of a few stamps.

(3) I had other sources of information.

(4) The French Academy of Medicine is understood to have adopted this treatment. It seems unlikely that the French War Office would use it in the treatment of soldiers, other than vivandières.

(5) The Honourable Member's reference is seemingly to morphine scopalamine. The anodyne I propose to experiment with it named "morphine desintoxiquée." The denunciation referred to by the Honourable Member appeared in the correspondence columns of the *American Journal of Obstetrics* for May last, over the name of Dr. Rudolph Wieser Holmes. In the editorial columns of the same issue a eulogy of amnesia, in normal as well as in abnormal obstetrics, appeared under the signature of Professor John O. Polak, M.D., F.A.C.S., of Long Island College Hospital, Brooklyn, New York City.

On July 7, 1915, Dr. Arthur, member for Middle Harbour, moved:—

(1) That a select committee be appointed to inquire into and report upon the prevalence of venereal diseases in this State, their effects upon the health of the community, and the means by which those effects can be alleviated or prevented.

(2) That such committee consist of Mr. G. Black, Mr. Millard, Mr. Stuart-Robertson, Mr. Morrish, Mr. T. Brown, Mr. Thomas, Mr. J. C. L. Fitzpatrick, Colonel Onslow, Mr. McGirr, and the mover.

In support of his motion, he stated that a great deal of mystery had been attached to the subject of venereal disease in the past, with disastrous results to the community. There had been an awakening of recent years, and intelligent people demanded that more light should be thrown on these subjects, and that, if possible, certain drastic steps should be taken to mitigate or prevent the effects of these diseases. He thought that it would be a mistake to hurry into premature legislation, and he had therefore urged the appointment of either a Royal Commission or a Select Committee to go into this matter. The motion was passed.

SOUTH AUSTRALIA.

In the opening speech of his Excellency the Governor of South Australia, delivered on July 8, 1915, in the Houses of Parliament, the following passages affecting the medical profession appear:—

"You will be asked to consider measures for dealing with venereal and other diseases, and to amend the Health Act.

"You will be asked to sanction the construction of a new Adelaide Hospital."

Medico-Legal.

THE SUSPENSION OF DR. D. F. BLANCHARD.

A short time ago, Dr. D. F. Blanchard was suspended from his position as District Medical Officer of Perth, and a Royal Commission, in the person of Mr. W. W. Alcock, was appointed to enquire into the charges preferred against him. The Royal Commission was formally opened on June 25, 1915, and the first session at which arguments were heard and evidence taken was on July 2, 1915. It was determined, on the application of Dr. Blanchard's counsel, that the evidence should not be published as it was given, but that the whole should be published after all the witnesses had been examined. The reference of the Royal Commission is as follows: To enquire into, and report upon, the charge of improper conduct preferred against Dr. David Francis Blanchard, District Medical Officer of Perth.

The charges are to the following effect: On March 1, 1915, Dr. Blanchard, in the abuse of the authority of his office, and for the purpose of gain, required or endeavoured to induce Police Constable O'Donoghue to cause one Ettie Brown to submit herself to bodily examination by Dr. Blanchard, and, further, between November 1, 1914, and March 1, 1915, Dr. Blanchard caused women to submit themselves to bodily examination by him, under the belief, induced by him, that otherwise they would be subject to interference by the police.

According to the opening statement of the counsel for the Department, Dr. Blanchard communicated with the Chief Inspector of Police, complaining of the laxity of the police in connexion with the conduct of houses of ill-fame, and suggesting that the police should take active steps in visiting these houses, in order that the presence of venereal disease might be ascertained. The reply given was that the police had no power to compel women to submit to medical examination. Dr. Blanchard would have been fully justified in charging the women a fee of one guinea per examination, which he did, had he acted in his private capacity, but it is urged that if he was acting in his private capacity, why did he apply for assistance to the police. If he was acting without police authority, and yet induced women to believe that he had such authority, then he was guilty of the second charge. The evidence is being heard with closed doors, but will be published at a later date. In the meantime, in fairness to Dr. Blanchard, no comment of any kind may be made.

EDWARD WILSON BEQUEST FOR CHARITIES.

The trustees of the Edward Wilson partnership share in the *Argus* have allotted £4,000 to various charitable institutions in Victoria. This amount forms the 75th half-yearly distribution of this philanthropic fund. A summary of the manner in which this fund was divided is appended:—

Hospitals	£ 930
Hospitals and Benevolent Asylums combined	135
Benevolent and Other Asylums	290
Refugees	55
Crèches	60
Convalescent Homes	50
Ladies' Benevolent Societies	275
Various Societies	275
	£ 2070
Special Donations (32)	1930
	£ 4000

In allotting the amounts to the 138 institutions, societies, homes and charities, the trustees take into account their actual financial positions.

University Intelligence.

UNIVERSITY OF SYDNEY.

At a meeting of the Senate of the University of Sydney, held on July 5, 1915, leave of absence was granted to Dr. A. E. Mills, lecturer in medicine, and to Dr. R. Gordon Craig, lecturer in clinical surgery. Both Dr. Mills and Dr. Gordon Craig are about to leave the Commonwealth on active military duty. Dr. C. B. Blackburn has been appointed in Dr. Mills's place during his absence, and Dr. St. J. W. Dansey will fill the post of lecturer in clinical surgery until Dr. Gordon Craig returns.

A letter was received from the Department of Defence, conveying the thanks of the Minister for the action taken by the Senate in providing medical graduates for active military service.

UNIVERSITY OF WESTERN AUSTRALIA.

A meeting of Convocation of the University of Western Australia was held on June 11, 1915, in the University buildings.

The Warden (Archbishop Riley) in his opening address, pointed out that it was impossible under existing conditions for the University to obtain more money from the Government. He referred to an agreement which had been arrived at with the various Australian universities, the University of Sydney excepted, in regard to the examination for degrees in music. Turning to the Workers' Educational Association, he stated that excellent work was being done, and that a longing for higher education was being created.

The number of students at the University had increased steadily. In 1913 there were 184, of whom 93 were matriculated. In 1914 there were 182, of whom 118 were matriculated, while in 1915 there were 214, of whom 132 were matriculated. He made suitable reference to the members of convocation who were at the front or about to leave for the front. It was with extreme regret that they had learned of the death of Captain Townshend and Lieutenant Ridgway. Dr. McWhae, too, had met with misfortune, and had lost an eye. He was a splendid man, and while they felt sorry that he had been wounded, they could but rejoice that he had escaped more serious injury. Lieutenant Southern, a promising student, was reported missing. Captain Townshend had served as registrar to the University. He was a man who had endeared himself to everyone with whom he had come into contact with.

Professor Whitfeld also spoke sympathetically of the loss sustained by the University on the death of Captain Townshend. He had felt that he had lost one of the best friends he had ever had. He moved that a message of sympathy be sent to his mother, who was living in Sydney. The motion was seconded by the Rev. J. J. Fitzgerald, and carried, all present standing.

The Warden (Archbishop Riley) was re-elected for a further term of office.

Certain amendments to statutes were proposed and adopted. The statutes, as amended, are as follows:—

Guild of Undergraduates.

1. The Guild of Undergraduates shall include all matriculated students who are proceeding to a degree at the University, and all unmatriculated students of the University who are in attendance at lectures and *bona fide* proceeding to a certificate, diploma, or licence, in respect of which they are required by the regulations for the time being of the University to attend lectures during a period of not less than six terms.

2. The Guild shall elect each year a council, which shall include one or more representatives of the students of each year in each of the Teaching Faculties of the University. At least two members of the council shall be women students.

3. The powers and duties of the council shall be:—
(i.) To represent the students in matters affecting their interests.

(ii.) To afford a recognized means of communication between the students and the University authorities.

(iii.) To promote social and academic unity among the students.

4. The annual subscription to the Guild shall not exceed two shillings and sixpence.

5. A copy of the annual balance sheet shall each year be forwarded to the Professorial Board for transmission to the Senate.

6. Subject to the provisions of this Statute, the Guild of Undergraduates may make rules for its internal management and administration, the election of its officers, the alteration of its rules, and all other matters requiring regulation, but all rules shall be subject to the veto of the Senate.

Public Examinations Board.

1. A Board for conducting school certificate examinations shall be constituted and shall be called the Public Examinations Board.

2. The Board shall consist of—

- (a) The Vice-Chancellor, *ex officio*.
- (b) Seven other members, representative of the University, who shall be appointed annually by the Senate, on the recommendation of the Professorial Board.
- (c) The Director of Education, *ex officio*.
- (d) Three other members, representative of the Education Department, who shall be appointed annually by the Minister of Education.
- (e) Three members, representative of such Secondary Schools for boys as are not under the Education Department and are recognized as Secondary Schools for this purpose by the Professorial Board. These members shall be elected annually by the headmasters of such schools.
- (f) Two members, representative of such Secondary Schools for girls as are not under the Education Department and are recognized as secondary schools for this purpose by the Professorial Board. These members shall be elected annually by the Association of Non-departmental Secondary Girls' School Teachers.

3. The Vice-Chancellor shall be, *ex officio*, Chairman. In his absence the Board shall appoint one of its members to act as chairman.

4. The Registrar or other officer appointed by the Senate shall act as Secretary to the Board.

5. All proceedings of the Board shall be entered in a journal.

6. The Board shall meet for the conduct of business at such times as may be determined by the chairman. If three members of the Board request, in writing, that a meeting shall be called, the chairman shall comply with their request.

7. All questions which come before the Board shall be decided by the majority of the members present. The chairman shall have a vote, and, in the case of an equality of votes, a second or casting vote. But no question shall be decided at any meeting unless seven members be present.

8. The Board shall consider all questions relating to public examinations for schools, and shall make recommendations thereon to the Senate.

9. The Board may consider questions relating to the conditions of matriculation, and for admission to courses for degrees or diplomas, and may make recommendations thereon to the Professorial Board.

10. The Board shall, after consultation with the respective examiners, prescribe all books and details of subjects for the public examinations.

11. The Board shall recommend to the Professorial Board such persons as it considers suitable for examiners.

12. The Board may require the papers set in any subject to be submitted to the Vice-Chancellor before they are printed.

13. The Board shall exercise control over the conduct of all public examinations for schools, and shall frame such regulations as are necessary for the purpose.

14. All decisions of the Board shall be subject to review by the Senate.

Professor Wilsmore gave a demonstration of the Nanson vote calculated system, and compared it with Ware's system of the single transferable vote.

Correspondence.

BACKWARDS OR FORWARDS.

Sir,—I should be greatly obliged if you would allow me enough space to make a few comments upon a paper by Sir Rickman Godlee, published in the *Medical Journal of Australia* for July 3. One feels a little diffident in criticizing

the remarks of so distinguished a surgeon, but the ideas expressed are so contrary to the convictions and experiences of so vast a number of surgeons who have lived in the period of transition from antiseptic to aseptic surgery that one cannot allow them to pass unchallenged.

The paper is most appropriately entitled, "Back to Lister," for it is "back" indeed, a long long way back, and an adoption of the principles advocated would be a very retrograde step. Fortunately a backward movement of this kind is unthinkable, for outside a few elderly English surgeons, the ancient faith in the virtue of chemical antiseptics has nearly vanished off the face of the earth.

When one looks back upon the dismal results which one remembers so well when the antiseptic regime held full sway, and our hospitals reeked with carbolic acid and iodoform, and contrasts them with the very different results obtained to-day, one is at a loss to conceive how anybody could advocate a policy of "back to carbolic." During my term as House Surgeon at Prince Alfred Hospital I saw one surgeon lose five consecutive cases of simple, clean abdominal section from septic peritonitis. Out of seven inguinal hernias six suppurated.

Following the surgical practice at the London Hospital for three months, I was convinced that their results were not much better, and I well remember my astonishment when I went to the Rotunda, and saw the results there under the aseptic system. In six months I never saw a trace of pus, or even serum, come from any wound, nor any patient get septic peritonitis, though silk was used for all ligatures and buried sutures. When one disagrees with a writer at almost every point it is hard to know where to begin.

The following phrase is the first to strike one: "The fact that healing takes place more readily in infancy than in old age." Does it? Infants notoriously resist sepsis far worse than adults, and the younger they are the worse they resist it. Elderly people, provided their heart and arteries, and especially their kidneys, are sound, heal remarkably well. The explanation is of course that a prolonged warfare with various organisms has conferred a high immunity upon them.

Then we come to the following astounding statement: "Others, however, being chiefly obsessed with the notion that antiseptics diminish the power of phagocytes maintained, etc." Contact with 5% carbolic would certainly diminish the power of phagocytes to do anything except die immediately. Does anyone really suppose that phagocytes could come into contact with any reasonably efficient antiseptic without being instantly killed? That is exactly the position which the aseptic surgeon takes up. Antiseptics which require prolonged exposure to kill bacteria will kill phagocytes and other body cells almost at once.

Again, Sir Rickman says: "Boiling instruments should, I think, be continued." This is a strange confession for an antiseptic surgeon to make. Of all things that come into contact with a wound instruments are by far the easiest to sterilize. If these potent chemicals can sterilize the surgeon's hands, and even the surfaces of wounds, surely the sterilizing of instruments would be mere child's play to them.

Again, he says: "Nor would I recommend the giving up of rubber gloves . . . although I know that they may be safely dispensed with by an antiseptic surgeon." If gloves can be safely dispensed with what possible reason can there be for using them? Undoubtedly one can work more quickly and dexterously without them. Indeed I believe that there are occasions when the surgeon does rightly to discard them. When manipulations are difficult and speed is necessary the patient may get more good from more rapid and gentler workmanship than he will get harm from the low virulence cocci which the ungloved hand always sheds upon the wound, that is, if he never allows his hands at any time to become contaminated with virulent organisms, for it is certain that by no known method can the hands be freed from them. One would think then that the antiseptic surgeon would greatly rejoice over the fact that he need not wear gloves. Yet it is not so, for he still prefers to wear them, though he knows that he can safely dispense with them. This is very strange and incomprehensible. I

do not wish to take up too much space, but I cannot resist making another quotation, this time without comment, for surely none is needed: "Reports from the front of almost universal sepsis made us fear that our prognostication had come true, and that abandonment of antiseptics was at least in part accountable. It appears, however, that antiseptics are being very largely used, though with most disappointing results."

There is no use in trying to reconcile antiseptics and asepsis; the two systems are founded upon opinions which differ radically. The aseptic surgeon believes:—

- (1) That antiseptics have little hope of killing germs which have once entered a wound, and none at all of killing those which have penetrated even the slightest distance into the tissues.
- (2) That such antiseptics as 1 in 20 carbolic, or 1 in 2000 perchloride, for example, are injurious to the tissues, and kill every phagocyte or other cell with which they come into contact, thus lowering the patient's power of resisting germs. They also greatly increase the serous discharges; this also favours the growth of germs.
- (3) That the hands cannot be sterilized, and therefore should be covered by rubber gloves except under certain exceptional circumstances.
- (4) That pyogenic germs are only killed by a fairly long contact with strong antiseptics; that spore-bearing anthrax is not killed by 5% carbolic in a month, but killed invariably by boiling water in less than fifteen minutes, and that therefore when one trusts to antiseptics, as in the case of catgut, one ought to leave the substance in contact with strong antiseptics for many days.
- (5) That as the patient's skin cannot be sterilized, instruments, ligatures, etc., should, as far as possible, be prevented from coming into contact with it.
- (6) That though no operation is absolutely aseptic, a few germs of low virulence are easily destroyed by the tissues, especially if these have not been injured by poisonous chemicals.

An antiseptic surgeon holds opinions contrary to these, and no amount of talk will bridge the gap. If one is right the other is wrong, and that is all there is to it.

Yours, etc.,

North Sydney (undated). ARTHUR S. VALLACK.

DR. OGG FUND.

Sir,—I have pleasure in handing you a detailed list of subscribers, and a receipt from Dr. Ogg for the amount subscribed.

The doctor desires to thank all subscribers and sympathizers with him in his affliction.

The total amount of subscriptions from the different States is as follows:—

	£	s.	d.
New South Wales	114	9	6
Victoria	6	6	0
Queensland	8	19	0
Western Australia	2	3	0
Total	£131	17	6

Personally, I have to thank you for your courtesy and kindness in this matter.

Yours, etc.,

G. STEVENSON.

Post Office Chambers,
Sydney, July 7, 1915.

[As announced in *The Medical Journal of Australia* of December 12, 1914, p. 578, the list referred to by Mr. Stevenson is open to inspection at the office of this journal. We regret that the amount collected is not larger, since Dr. Ogg is totally unprovided for, and is quite incapable of helping himself.]

THE LATE MRS. PURCHAS.

Sir,—In your kindly notice, in the issue of 20th June, of the death at Alexandria of my brother's wife, there is some inaccuracy. Mrs. Purchas was not a member of the nursing profession, but joined her husband at Cairo, and when

his battery (howitzer) went to Gallipoli, she offered her services at the Alexandria Military Hospital. Her offer was accepted, and she worked in an entirely voluntary capacity up to the time of her death.

As a mark of the appreciation of her help, she was accorded a military funeral. Major A. C. Purchas is in charge of a hospital ship, and their boy of nineteen is among the wounded, and three nephews are with him, and a fourth is on his way, all with the New Zealanders.

Yours, etc.,

J. M. PURCHAS.

Young, July 8, 1915.

Medical Appointments.

Dr. A. E. Barrington has been appointed Officer of Health for Benalla Shire, Victoria, in place of the late Dr. John Nicholson.

Dr. Frank Tipping has been appointed Officer of Health for Lawloit Shire, Victoria, in place of Dr. R. G. West (resigned).

The following temporary appointments have been made on the Melbourne Hospital staff:—

Dr. W. S. Garnett, Acting Physician to Out-Patients.

Dr. T. S. Campbell, Acting Assistant Anaesthetist, and Acting Medical Clinical Assistant.

Dr. G. W. Armstrong, Acting Dermatologist.

Dr. J. L. Davis, Acting Surgical Clinical Assistant.

Dr. F. C. Andrew, Acting Clinical Assistant to Officer for Diseases of the Ear, Nose and Throat.

Dr. Rachel Cross, Acting Clinical Assistant to Dermatologist.

The following has been published in the New South Wales Government *Gazette*, No. 124, under date of July 7, 1915:—

Department of Public Health.

Woods, James Joseph, Probationary Attendant, on probation. Salary, £118 per annum.

Hamlet, William Mogford, F.I.C., F.C.S., Relieving Government Analyst. Salary, £700 per annum.

Cooksey, Thomas, F.I.C., Ph.D., B.Sc., Government Analyst. Salary, £500 per annum.

Doherty, William Michael, F.I.C., F.C.S., Second Government Analyst. Salary, £400 per annum.

Walton, Sidney Gilbert, Senior Assistant Government Analyst. Salary, £275 per annum, ranging to £300.

Taylor, Harold Burfield, B.Sc., Assistant Government Analyst, on probation. Salary, £150 per annum.

Dibley, Arthur Doulton, B.Sc., Laboratory Assistant. Salary, £95 per annum.

Duncan, George Meston, M.B., Junior Assistant Medical Officer, Lunacy Department, on probation. Salary, £300 per annum, ranging to £350, and allowances valued at £99.

Henry, Clifford, M.B., Junior Assistant Medical Officer, Lunacy Department, on probation. Salary, £300 per annum, ranging to £350, and allowances valued at £99.

Kirk, Esmond James, Junior Clerk, Head Office, on probation. Salary, £60 per annum, with living allowance of £25.

Condie, Henry John, Junior Clerk, Lunacy Department, on probation. Salary, £60 per annum.

The following appointments have been announced in the South Australian Government *Gazette*, dated July 8, 1915:—

His Excellency the Governor in Council has been pleased to make the undermentioned appointments in the Adelaide Hospital, viz.:—

Honorary Surgeons: Benjamin Poulton, M.B., M.R.C.S., and Charles Edward Todd, M.B., M.R.C.S., L.R.C.P.

Honorary Assistant Surgeons: Henry Simpson Newland, M.B., M.S., F.R.C.S., and William Rolan Cavanagh-Mainwaring, F.R.C.S.

Honorary Physicians: Harry Swift, M.D., M.R.C.S., and Elward Angus Johnson, M.D., Ch.P., M.R.C.S.

Honorary Assistant Physician: John Bernard Gunson, L.R.C.P., M.R.C.S.

Honorary Gynaecologist: Thomas George Wilson, M.B., Ch.M., F.R.C.S.

Honorary Assistant Gynaecologist: Arthur Francis Lynch, M.B., B.S.

Honorary Dermatologist: Rowland Edward Harrold, M.B., Ch.M.

Honorary Surgeon, Ear, Nose and Throat: George Alfred Fischer, M.B., B.S.

Honorary Dental Surgeon: Alexander LeFrouda White.

Drs. J. S. C. Elkington, F. E. Cox, N. W. Markwell, C. L. Park, R. U. Russell, F. Hone, W. B. Nisbet, S. McClintock, G. H. Hogg, J. W. Hope, D. Williams and G. H. S. Blackburn have been appointed Quarantine Officers authorized to administer oaths or affirmations and to take declarations, as provided in section 6 (c) of the Quarantine Act, 1908-12.

Dr. Norman Walter Markwell has been appointed an "Officer" under the Immigration Act, 1901-1902, at Thursday Island, in place of the late Dr. Wassell.

Dr. Edward Ernest Moule has been appointed Acting District Medical Officer and Public Vaccinator at Wagin, Western Australia, during the absence of Dr. Philip Nutting.

Dr. W. Kennedy has been appointed Officer of Health to the Corrigin Road Board (Western Australia), in the place of Dr. Moore, who has resigned.

Dr. F. J. Elliott has been appointed Acting District Medical Officer and Public Vaccinator for Derby, Western Australia, during the absence of Dr. Gurdon, on sick leave.

Dr. Isaac George has been appointed Acting District Medical Officer and Public Vaccinator at Tambellup, Western Australia, during the absence of Dr. Lovegrove.

Dr. P. H. Nutting has been appointed District Medical Officer and Public Vaccinator at Busselton, in the place of Dr. Lionel Joseph Robertson, who has resigned.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page ix.

Royal Hospital for Women, Paddington, Resident Medical Officer.

New Guinea, Government Medical Officer.

Books Received.

A MANUAL OF GYNÆCOLOGY FOR STUDENTS AND PRACTITIONERS, by Samuel J. Cameron, 1915. London: Edward Arnold. Royal 8vo., pp. 552. Illustrated. Price, 18s.

THE PRACTICAL MEDICINE SERIES, Vol. II, General Surgery, by Charles L. Mix, A.M., M.D., and Roger T. Vaughan, Ph.B., M.D. Edited by John B. Murphy, A.M., M.D., LL.D., F.R.C.S., F.A.C.S. Series 1915. Chicago: The Year Book Publishers. Demi 8vo., pp. 602. Price \$2.

THE MEDICAL ANNUAL, 1915, by Several Contributors, 1915. Bristol: John Wright & Sons, Ltd.; Demy 8vo., pp. 659, with illustrations, some coloured. Price, 11s.

Diary for the Month.

- July 17.—N. Suburbs Med. Assoc., N.S.W., General.
- July 20.—N.S.W. Branch, B.M.A., Executive and Finance Committee, Ethics Committee.
- July 21.—Vict. Branch, B.M.A., Clinical Evening.
- July 21.—W. Suburbs Med. Assoc., N.S.W., Clinical Evening.
- July 21.—W. Aust. Branch, B.M.A., General.
- July 23.—Q. Branch, B.M.A., Council.
- July 27.—Vict. Branch, B.M.A., Eye and Ear Section.
- July 27.—N.S.W. Branch, B.M.A., Organization and Science Committee, Medical Politics Committee.
- July 28.—Vict. Branch, B.M.A., Council.
- July 29.—South Aust. Branch, B.M.A., Monthly.
- July 30.—N.S.W. Branch, B.M.A., Ordinary.
- Aug. 4.—North. Dis. Med. Assoc. (Tamworth).
- Aug. 4.—Vic. Branch, B.M.A., Monthly.
- Aug. 6.—Queensland Branch, B.M.A., Monthly.

Aug. 11.—Melb. Pædiatric Soc.

Aug. 12.—North Eastern Med. Assoc. (Tamworth), N.S.W.

Aug. 12.—Vic. Branch, B.M.A., Council.

Aug. 13.—N.S.W. Branch, B.M.A., Clinical Evening.

Aug. 13.—S. Aust. Branch, B.M.A., Council.

Aug. 17.—N.S.W. Branch, B.M.A., Executive and Finance Committee, Ethics Committee.

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Branch.

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(Hon. Sec. B.M.A. Building, Adelaide Street, Brisbane).

Brisbane United F.S. Institute.
F.S. Lodges at Longreach.

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(Hon. Sec. 230 St. George's Terrace, Perth).

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All Contract Practice Appointments in W.A.

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F.S. Lodges at Orange.
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